NORTH CAROLINA COMMISSION
FOR MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

and the

NORTH CAROLINA DIVISION OF
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

THE Workforce Development INITIATIVE

April 15, 2008

The Workforce Development Initiative

The North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services

Pender McElroy, Chairman

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Subcommittees of the Workforce Development Initiative

Governance Subcommittee

Advisory Committee Co-Chair: Tom Ryba
Division Co-Chair: Michelle Edelen
Advisory Committee Members: Robin Huffman, John Tote, Martha Macon, Laura Coker, Ann Forbes
Division Staff: Monica T. Jones

Data and Information Subcommittee

Advisory Committee Co-Chair: Clayton Cone
Division Co-Chair: Rebecca Carina
Advisory Committee Members: Carl Shantzis, Laura Coker
Division Staff: Jacqui Harrison, Michael Schwartz

Professional and Direct Support Staff Development Subcommittee

Advisory Committee Co-Chair: Marvin Swartz
Division Co-Chair: Steven Hairston
Advisory Committee Members: Judy Lewis, Karen Stallings
Division Staff: Leesa Galloway, Sheila Bazemore, Markita Keaton

Participants in this subcommittee also included representatives from
The North Carolina Council on Developmental Disabilities: Holly Riddle, Executive Director, Larry Swabe, Jason Laws

Regulatory Subcommittee

Advisory Committee Co-Chair: Dave Richard
Division Co-Chair: Denise Baker
Advisory Committee Members: Emily Moore, Bob Hedrick, Dorothy Crawford, Chris Egan
Division Staff: Marta Hester

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Executive Summary

In state fiscal year 2007, the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (the Commission) and the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) undertook a joint initiative to assess growing concerns about the workforce situation in North Carolina and make recommendations for action.

Concerns about the workforce had arisen as a result of national trends, the ongoing transformation of the North Carolina public mental health, developmental disabilities and substance abuse services system and the resulting increase in demands for services in communities and changes made in state-operated facilities.

The Commission and the Division formed four subcommittees as defined below to clarify the purpose of the initiative and to examine the current status of the workforce serving the consumers of public mental health, developmental disabilities and substance abuse services.[1] The Commission and the Division invited the North Carolina Council on Developmental Disabilities (the DD Council) to participate in the Professional and Direct Support Staff Development Subcommittee. Consultants from the Annapolis Coalition, the Research and Training Center on Community Living of the University of Minnesota, and the Paraprofessional Healthcare Institute provided national perspectives to the effort.

Subcommittee	Activities
Governance Subcommittee	Defined the purpose, mission and vision of the workforce development initiative.
Data and Information Subcommittee	Researched labor market information, current and projected population and demands for services.
Professional and Direct Support Staff Development Subcommittee	Identified workforce development partners, held focus groups with stakeholders and identified strategies for recruitment, retention and training.
Ad Hoc Subcommittee on Regulatory Matters	Reviewed the effects of current statutes, rules and policies and recommended needed changes.

Definitions and Language

For purposes of this initiative, the term "workforce" includes individuals in training or currently employed to manage or provide health promotion, prevention, and treatment services and supports for persons with mental health conditions, or substance abuse or substance abuse

[1] Membership of the subcommittees is shown inside the front cover.

disorders, or developmental disabilities, or co-occurring disorders. Individuals in the workforce may have graduate training, associate's or bachelor's degrees, high school diplomas or less formal education. In addition, consumers of services and their family members are recognized as having critical roles in caring for themselves and each other, whether informally or more formally through organized peer- and family-support services.

The credentials and qualifications that apply to staff of the system are defined in North Carolina Administrative Code.[2] These include associate professionals, certified substance abuse professionals, directors, licensed professionals, nurses, paraprofessionals, psychiatrists, psychologists, qualified client record managers, qualified professionals and qualified substance abuse prevention professionals. The code allows for the establishment of a competency-based employment system for qualified professionals, associate professionals and paraprofessionals.

The term "community services and supports" refers to all services provided in the community for any of the populations served. "State-operated services" refer to the services provided in the facilities operated by the Division including psychiatric hospitals, alcohol and drug abuse treatment centers, developmental centers, residential programs for children, and neuro-medical treatment centers.

"Clinical services" mean active direct treatment and habilitation, such as counseling, medication management, diagnostic assessment and detoxification. They are primarily provided in an office or clinical setting, including state-operated facilities, by qualified professionals or associate professionals.

"Direct support services" are typically provided in the homes of families and in the community. These services enable consumers, whether adults or children, to live in community settings and to participate within the environment of their family's culture. The workforce of direct support service roles predominantly consists of bachelor's level employees and individuals with high school diplomas or GED diplomas, otherwise identified as paraprofessionals.

The term "direct support workers" has traditionally referred to the workforce providing services and supports for persons with developmental disabilities. Currently, direct support workers play a vital role in the lives of people with developmental disabilities, mental health needs, substance abuse challenges and their families, as well as the aging population. They assist people with a wide range of activities such as help with maintaining a home, finding work, transportation, making important decisions, taking medications, learning new skills, personal care, and connecting with other people and activities.[3]

Direct support services are also compatible with the system of care approach used in the field of children's mental health. The combination of direct support services with traditional clinical services have been found to be the most successful for children with challenging needs as evidenced by Multi-Systemic Therapy, an evidence-based practice, or Intensive In-Home service. Clinicians provide consistent and frequent supervision to ensure that direct support workers are prepared to meet the challenges that are inherent in their jobs from understanding

[2] See appendix D of this document for a copy of this statute 10A NCAC 27G .0104.
[3] See Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007.

basic theories of behavior, to possessing strong listening and communication skills, and other skills as well as support for practical aspects of the job such as scheduling and coverage.

While other health and human service providers, such as primary care providers, emergency room staff, and others have major roles in responding to the needs of consumers of public mental health/developmental disabilities/substance abuse services, those segments of the workforce are not addressed in this initiative.

General findings

National studies indicate that a workforce crisis is occurring across the nation in healthcare and human services. As stated by the Annapolis Coalition on the Behavioral Health Workforce:

> "There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. … There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services."[4]

These findings are further supported by a recent report of the North Carolina Institute of Medicine that states: "The state is likely to face a severe shortage of physicians, nurse practitioners, physician assistants and certified nurse midwives over the next 20 years".[5] The North Carolina Institute of Medicine identified four primary challenges:

1. Growth in provider supply will not keep pace with the growth in North Carolina's healthcare needs.
2. Many areas of the state are currently experiencing provider shortages.
3. There is a significant mal-distribution among certain specialties across the state.
4. The existing workforce does not reflect the state's diverse population.

To identify the workforce issues currently facing stakeholders of North Carolina's public mental health, developmental disabilities and substance abuse services system, the subcommittees collected available data from professional boards and various state agencies including the North Carolina Employment Security Commission.

Population Growth: Trends in North Carolina's population indicate both the probable future demands for services as well as the probable availability of workers. By 2014, the projected population in North Carolina will be between 9.5 and 10 million people, up from 8.5 million in 2005. The United States Census Bureau has projected that North Carolina will become the

[4] Annapolis Coalition on the Behavioral Health Workforce, An Action Plan for Behavioral Health Workforce Development, A Framework for Discussion, Executive Summary, 2007, pp. 1-2.
[5] North Carolina Institute of Medicine, *Providers in Demand: North Carolina's Primary Care and Specialty Supply*, June 2007, p. 13.

seventh most populous state by 2030, with over 12.2 million residents. Growth is projected in the number of retirees and in both the Asian and Latino populations.

Economic and Workforce Trends: In 2006, the number of people over 16 years of age in the North Carolina labor force was approximately 4,520,961. Fifty-nine counties in North Carolina had unemployment rates at or below 5 percent in 2006.[6] However, counties that traditionally have emphasized manufacturing and agriculture have experienced higher rates of unemployment due to loss of jobs as industries closed or relocated. Often, problems with substance abuse and depression affect dislocated workers.

A clear assessment of the current public MH/DD/SAS workforce for comparison of local needs with currently available staff and their skills was not possible due to the lack of readily available or easily accessible data.[7] Through focus groups with providers, consumers and LMEs, significant problems were identified, such as a high rate of turnover among staff that provides the majority of direct care and support for MH/DD/SAS consumers, and inconsistent or lack of adequate supervision. As the population grows, the need for a competency-based, well-trained, stable MH/DD/SAS workforce also grows.

Prevalence of MH/DD/SA Consumers: North Carolina has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the prevalence (percent of the population estimated to have a particular condition in a given year) to the treated prevalence (percent of the population in need who actually receive services for that condition within a year).

Consumers of community-based federal or state funded services SFY 2007[8]

Services	Persons served	Treated prevalence
Adult mental health	128,883	38%
Child mental health	82,363	41%
Adult developmental disabilities	17,879	36%
Child developmental disabilities	9,977	19%
Adult substance abuse	40,588	7%
Child substance abuse	3,152	6%

Other specific concerns affecting programs of the public MH/DD/SAS system include increases in the number of children diagnosed with autism; the number individuals with traumatic brain injury resulting in significant cognitive, behavioral and communicative disabilities and long-term medical complications; the number of veterans with post traumatic stress syndrome, suicides, substance abuse problems, and other responses to the war in Iraq; and in the number of veterans' family members with mental health and substance abuse problems.

[6] Employment Security Commission of NC, October 2006.
[7] Even the attempt to identify this workforce through the Employment Security Commission database was unsuccessful, because providers use various job classifications that do not match the job titles used by LMEs, the Office of State Personnel, or the Employment Security Commission.
[8] DMHDDSAS. Community Systems Progress Indicators. December 3, 2007.

Additionally, the Commission and the Division took action to obtain the perspectives of individuals with disabilities and their families, providers, human resource managers, educators, direct support workers and supervisors through focus groups and listening sessions. The Division partnered with the Behavioral Health Care Resources Program (BHRP) in the School of Social Work of the University of North Carolina at Chapel Hill to administer surveys and conduct focus groups across North Carolina.[9] The DD Council contracted with the Research and Training Center on Community Living, University of Minnesota to hold listening sessions regarding the challenges individuals with disabilities and their families face and ideas about solutions.[10]

Key issues emerged as needing immediate attention:

- There are an inadequate number of supervisors within the system and a strong need for improvement in the quality of both management and clinical supervisory skills.
- There is need for review, clarification, and/or revision of current mental health, developmental disabilities and substance abuse services rules, especially regarding competency-based staff qualifications.
- There are both a shortage of and a mal-distribution of psychiatric and other professional and direct support staff across the state.
    - The differences in urban versus rural areas are significant.
    - There is a high rate of competition for available professionals.
    - There are chronic vacancy rates among nurses, pharmacists, physical therapists, occupational therapists, recreational therapists, healthcare technicians, substance abuse counselors, and mental retardation habilitation coordinators at state operated facilities.
- There is a high rate of turnover among staff that provides the majority of direct care and support for consumers and there is difficulty in filling staff vacancies. Precipitating problems appear to be the effect of part time work, an inadequate living wage, poor or absent supervision, lack of benefits, unreliable schedules, no career ladder and lack of adequate training.
- There is insufficient data about the current public mental health, developmental disabilities and substance abuse services workforce that is needed for adequate planning and monitoring.

Long-term issues include:

- Along with projections of a growing and aging population, and thus increased demands for services, there is a corresponding projection that the number of providers and the workforce are not growing at an adequate rate.
- An aging and growing population with longer life expectancies is driving the projections of 700,000 new jobs in North Carolina by 2014 with a majority in healthcare support; healthcare practitioners and technicians; and education, training and library leading to competition for a workforce that is not growing at the same rate as the population to be served.[11]

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[9] See appendix F for a report by the Behavioral Health Care Resources Program.
[10] See Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007.
[11] See the Employment Security Commission of North Carolina News Release dated February 26, 2007 at http://www.ncesc.com.

In summary, the Commission and the Division found that North Carolina's public mental health, developmental disabilities and substance abuse services workforce does face significant challenges consistent with the deepening national health and human services workforce crisis.

Conclusions and Recommendations

Clearly, a decision point is at hand and now is the time to take action while these issues are receiving national, state and local attention. Recognizing this is a large and complex issue, the Commission and the Division are in agreement with the North Carolina Institute of Medicine and many other professional and trade associations in North Carolina that prompt action is needed to build a workforce that is adequate in both numbers and quality to meet the needs of the populations we serve.

Building a viable, adequate and quality workforce requires (1) a collaborative effort among state agencies, universities, community colleges, other educational institutions, professional organizations, LMEs, providers, consumers and their families, and their advocates; and (2) effective methods to operate and carry out strategies to retain, recruit and train people who make up the workforce in community-based services and supports and in state-operated facilities. As stated by the Annapolis Coalition in its Executive Summary:

> "If the behavioral health field is to address the workforce crisis seriously, a number of key elements will be required: a clear vision; a practical blueprint; a structure for implementation; methods for monitoring progress; collaboration across the various sectors in the field and careful attention to the levers of change." (page 24)

Therefore, the Commission and the Division identified 12 recommendations as shown in table 1. Each recommendation is discussed in detail in the final chapter of this report.

The Commission and the Division recognize that implementation of these recommendations requires additional funding. Funding is needed for:

- Support of the workforce development initiative.
- Marketing and raising public awareness and promotion of the careers.
- Educational institutions in securing relevant clinical and management curricula using a variety of training media.
- Ongoing training for management, clinical and direct support staffs.
- Collecting and analyzing data for monitoring the needs for a current and future workforce in communities and in state operated facilities.
- A variety of recruitment and retention strategies such as loan repayment programs and state-wide benefits for workers.

Table 1. Recommendations for the Development of North Carolina's Mental Health, Developmental Disabilities and Substance Abuse Workforce

STRUCTURES TO SUPPORT THE WORKFORCE
***Recommendation 1**: Develop a detailed plan of action for implementation of these recommendations under the oversight and involvement of the Commission and the Division.*
***Recommendation 2**: Create a consistent means to identify data and other information about the status of the North Carolina public mental health, developmental disabilities and substance abuse services workforce as a quality improvement function and report annually to policy makers.*
***Recommendation 3**: Employ within the Division a Workforce Development Specialist who has expertise in the assessment of workforce issues and development of solutions and who will serve as the project manager for carrying out the plan of action for implementing the recommendations identified in this report and other workforce initiatives of the Division.*
BROADENING THE CONCEPT OF WORKFORCE
***Recommendation 4**: Create new service options for consumer directed services for all individuals with disabilities and, as appropriate, for their families.*
***Recommendation 5**: Create a workforce marketing and public awareness campaign for all types of staff positions in the public mental health, developmental disabilities and substance abuse services system.*
STRENGTHENING THE WORKFORCE
***Recommendation 6**: Optimize wages and benefits for professional and direct support workers serving consumers of the public mental health, developmental disabilities and substance abuse service system.*
***Recommendation 7**: Create selection tools to assist providers in reducing early turnover of workers.*
***Recommendation 8**: Improve access to psychiatric, other medical and non-medical care for individuals served by the public mental health, developmental disabilities and substance abuse service system.*
***Recommendation 9**: Create coordinated competency-based curricula and certification plans for professional and direct support workers.*
***Recommendation 10**: Provide systematic training, technical assistance and incentives to all providers statewide on effective recruitment, retention and training practices.*
***Recommendation 11**: Foster, encourage and support system wide training to frontline supervisors and managers on effective supervision.*
***Recommendation 12**: In order to create positive work environments, provide opportunities to empower professional and direct support workers serving consumers of publicly funded mental health, developmental disabilities and substance abuse services.*

Introduction

The North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services (the Commission) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) combined their efforts to undertake a comprehensive look at workforce development as it relates to the provision of public mental health, developmental disabilities and substance abuse services in the state.

Background of this Initiative

In state fiscal year 2007, the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (the Commission) and the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) undertook a joint initiative to assess growing concerns about the workforce situation in North Carolina and make recommendations for action.

Concerns about the workforce had arisen as a result of the ongoing transformation of the North Carolina public mental health, developmental disabilities and substance abuse services system and the resulting increase in demands for services in communities and changes made in state-operated facilities.

The Commission and the Division formed four subcommittees to clarify the purpose of the initiative and to examine the current status of the workforce serving the consumers of public mental health, developmental disabilities and substance abuse services.[12] The Commission and the Division invited the North Carolina Council on Developmental Disabilities (the DD Council) to participate in the Professional and Direct Support Staff Development Subcommittee. Consultants from the Annapolis Coalition, the Research and Training Center on Community Living of the University of Minnesota, and the Paraprofessional Healthcare Institute provided national perspectives to the effort. The initial tasks for each subcommittee are shown in table 2.

This report provides the joint findings and recommendations for immediate and long-term development of the workforce to meet the demand of the residents of North Carolina for mental health, developmental disabilities, and substance abuse services and supports.

There are three companion reports to this effort:

1. Behavioral Healthcare Resource Program, School of Social Work, UNC-CH, *Results of Focus Groups on Workforce Issues in Mental Health Systems Transformation in North Carolina*, July 2007. See appendix F.
2. Amy Hewitt, et al., *Direct Support Professional Work Group Report*, October 2007. Contact the NC Council on Developmental Disabilities for a copy of this report.

[12] Membership of the subcommittees is shown inside the front cover.

3. *Psychiatrists, Licensed Mental Health Professionals, Certified/Licensed Substance Abuse Professionals, and Persons Needing Mental Health Or Substance Abuse Services in North Carolina By County, 2006,* prepared by Quality Management Team, Community Policy Management Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services, March 2007.

Table 2. Subcommittee tasks on Workforce Development

Subcommittee	Tasks
Governance: What are the goals of the workforce development?	1. Provide the purpose of this workforce development plan. 2. Outline the vision, mission, value and objectives statements. 3. Include the importance of quality management in and of the workforce system.
Data and Information: What should the public workforce development system look like?	1. Research labor market information about current and future occupational trends among the workforce in North Carolina. 2. Research information about the overall population trends and projections. 3. Collect and analyze information about the current demand for services and the current workforce for mental health, developmental disabilities and substance abuse services. 4. Project future demands for services and workforce for the mental health, developmental disabilities and substance abuse services system.
Professional and Direct Support Workers: Who is qualified and responsible to provide what services?	1. Identify all the partners in the workforce – public & private – and their roles and obligations, including the Division, providers, local management entities (LMEs), advocates, consumers and educational institutions. 2. Identify strategies to recruit, train and retain the workforce. 3. Identify strategies to initiate, organize and mobilize partnerships.
Regulatory: What are the regulations, rules and policy responsibilities in the workforce system?	1. Identify the effects of statutes, rules, regulations and policy guidelines on the workforce. 2. Identify needed changes in rules or policy.

The Purpose of the Workforce Development Initiative

In 2001, the North Carolina General Assembly passed legislation to reform the state's mental health, developmental disabilities and substance abuse services system.[13] The major emphasis of reform included enhancement of community-based services, person-centered planning and the involvement of consumers and families, and downsizing of state-operated facilities.

These changes in North Carolina occurred concurrently with a national shift in the delivery of mental health and substance abuse services.[14] The U.S. Supreme Court's ruling in the case of Olmstead vs. L. C. has a profound impact on the state operated facilities by emphasizing the rights of consumers to receive services in community settings rather than in large institutions.

Given the emphasis on community-based services, a major result of the reform legislation was the shift from area and county programs that provided all local mental health, substance abuse and developmental disabilities services to residents in their area, to the establishment of local management entities (LMEs) funded to administer and manage a local system of private providers. Over the last six years, some area and county programs divested the services they once delivered to establish successful private provider agencies. Some were not successful. It is not clear what happened to the clinical workforce that was not retained by local management entities (LMEs) in their new roles as administrators or managers. In the process there was loss of historical knowledge and staff experienced in working with the populations served.

On the other hand, provider organizations that existed prior to reform in North Carolina or in other states took a "wait and see" attitude until the state obtained approval from the federal Centers for Medicare and Medicaid Services (CMS) of new services that would be reimbursed through Medicaid. Understandably, these organizations were unwilling to hire new staff until service definitions were approved given their specification of provider qualifications and staffing requirements for each service.

CMS approved new mental health and substance abuse services in December 2005. The Division implemented the approved services as of March 20, 2006 after allowing time for providers to submit applications, for LMEs to endorse providers for specific services, and for the Division of Medical Assistance to enroll providers for Medicaid reimbursement of services.

Even after the implementation of the new service definitions on March 20, 2006, private providers that were conditionally endorsed by an LME and enrolled by Medicaid were given 18 months to become fully staffed. That time period ended September 20, 2007, at which time a provider was to be fully enrolled to continue to provide services.

In the meantime, the Division developed a separate Community Alternatives Program (CAP-MR/DD) waiver of services for consumers with developmental disabilities that was approved by

[13] See Session Law 2001-437 (House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level).
[14] See the President's New Freedom Commission on Mental Health and the Robert Wood Johnson Foundation "Advancing Recovery" program.

CMS and implemented in September of 2005. Nearing the end of that three-year waiver, the Division is currently in the process of developing a new waiver package including service definitions, provider qualifications and staffing requirements. The Division anticipates that some of the roles of the staff providing services will change as a result of this waiver.

Activities were also underway to downsize the state psychiatric hospitals and developmental centers, to replace the aging facilities at Dorothea Dix and John Umstead psychiatric hospitals with a new Central Regional Hospital, to transform three specialized nursing facilities into neuro-medical centers, and to increase the capacity of the alcohol and drug abuse treatment centers.

These and other factors affected the establishment of new community providers of services and, thus, the overall public mental health, developmental disabilities and substance abuse services workforce in North Carolina.

National Perspective

At the same time that North Carolina was experiencing workforce challenges, they were also being felt at the federal level. In 2000, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition on the Behavioral Health Workforce to develop a workforce action plan that was national in scope. This was in response to growing national concern and pessimism about the relevance and effectiveness of efforts to develop a future workforce for serving individuals with mental health conditions, substance abuse or substance use disorders and co-occurring mental and addictive conditions.

According to the Annapolis Coalition, "…there is a national crisis in the training of the behavioral health workforce." This crisis is a result of:

> (1) Education and training programs not keeping pace with the changes in mental health care created from managed care and mental health care reform.
> (2) Direct care staff (that have the most contact with consumers) often receive the least amount of education and training.
> (3) "Consumers and families, who play an enormous care-giving role, typically receive no educational support, nor is their unique knowledge and experience used in the training of other members of the workforce."[15]

The standards set forth in the federal Centers for Medicare and Medicaid Quality Framework established expectations for enhancing the quality of the direct support workforce.[16] As reported to the Commission by its subcommittee on professional and direct support workers:

> "In the areas of Provider Capacity and Capabilities the CMS standards require that there are sufficient numbers of qualified providers (this includes direct support providers) to meet the needs of service recipients. The difficulty of retaining existing direct support

[15] The Annapolis Coalition on the Behavioral Health Workforce, An Action Plan for Behavioral Health Workforce Development, A Framework for Discussion, Executive Summary, 2007. See: http://www.annapoliscoalition.org/
[16] See: http://www.cms.hhs.gov/

workers coupled with the increase in demand for this group of workers is a direct threat to this capacity."[17]

Nationwide, this situation directly impacts the provision of services in communities for individuals with developmental disabilities, mental illness, substance abuse, or the aging and their families.

Governance

Given these national perspectives and the increased demand for services from North Carolina's consumers and families, and increased demand from providers and local management entities (LMEs) to strengthen the system's workforce, the Governance Subcommittee undertook a philosophical discussion of the purpose of this workforce development initiative. This work resulted in statements of purpose, vision and mission, which take into account the vision, mission, and guiding principles of the Division and its recent State Strategic Plan 2007-2010.[18] Clearly, the accomplishment of the objectives of the State Strategic Plan and the full implementation of system transformation are dependent on a well trained and robust workforce. Quality management is an essential part of the workforce system. As a result, the following statements were prepared by the Governance Subcommittee and were approved in May 2007.

Purpose

The "Blueprint for Change" initiated in 2001 has resulted in broad changes in North Carolina's mental health, developmental disabilities, and substance abuse workforce at every level. Consequently, a reassessment of the type, numbers, education, qualifications, compensation, expectations, and resources to be integrated throughout the service delivery workforce needs to be completed.

Mission

North Carolina's mental health, developmental disabilities and substance abuse Workforce Development Initiative will be the roadmap to the preparation of a competent, stable, knowledgeable, and appropriately compensated workforce that sustains the comprehensive, community-based, customer-guided system of care.

Vision

The Workforce Development Initiative will produce professionals who will proclaim they are appreciated, well-educated, competitively compensated, highly professional in their interactions with peers and consumers, and whose job satisfaction will lead to a lifetime commitment to providing exemplary customer-guided mental health, developmental disability and substance abuse services in North Carolina.

[17] Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007, page 2.
[18] See: http://www.ncdhhs.gov/mhddsas/stateplanimplementation/index.htm

Workforce Development: An Environmental Scan

The success of any system, business or organization depends on the ability to adapt to a changing external environment. In this day and age, social, technological, economic and political variables are changing rapidly and in unexpected directions. Lead time for managers to analyze and respond to changes in the environment is decreasing. Managers of healthcare organizations, educational institutions, and governmental agencies as well as other systems or businesses can no longer assume that future changes will continue in the direction and at a similar rate of past trends.

This is particularly applicable for the current transformation of services for individuals with mental illness, substance abuse and developmental disabilities in North Carolina. Transformation of the system caused a rapid shift from what has been called a "one-stop shop" at the area or county mental health program to a market-driven and private provider system.

The North Carolina Institute of Medicine (NC IOM) states: "Growth in the provider supply has not kept pace with growth in the overall population or the increased demand for health services in North Carolina." The NC IOM report was produced by a task force to analyze current and projected trends in provider supply and to examine the current production of specific healthcare providers. NC IOM concluded: "The state is likely to face a severe shortage of physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) over the next 20 years."[19]

One of the questions is how to assess the impact of changes in the environment on a system or organization. For the public mental health, developmental disabilities and substance abuse services system, environmental scanning is one of the possible tools.[20] Environmental scanning involves examining trends and issues important to healthcare in North Carolina regarding:

- North Carolina's general population and workforce.
- General occupational changes, potential threats and opportunities that affect healthcare.
- Scientific, economic, and political changes affecting the workforce and demand for services.
- Current and projected future workforce.
- Current and projected future demand for public mental health, developmental disabilities and substance abuse services and supports.

To this end, and with the assistance of staff from the Labor Market Information Division of the Employment Security Commission of North Carolina, the Data and Information Subcommittee researched and analyzed relevant data regarding North Carolina's population, labor market, projections of the future workforce, the current workforce of the public mental health,

[19] North Carolina Institute of Medicine, *Providers in Demand: North Carolina's Primary Care and Specialty Supply*, June 2007, page 13.

[20] Environmental scanning is a method that enables decision makers both to understand the external environment and the interconnections of its various sectors and to translate this understanding into planning and decision making processes.

developmental disabilities and substance abuse services system, occupational trends for services provided and an analysis of overall population trends and projections.

In addition, these data were compared to the current and projected demand for services based on trends in the general population and for individuals with the disabilities that the system serves. These data are summarized in this report and in a companion Division report entitled, *"Psychiatrists, Licensed Mental Health Professionals, Certified/Licensed Substance Abuse Professionals, and Persons Needing Mental Health or Substance Abuse Services in North Carolina by County, 2006.*

North Carolina's General Population and Workforce

As of July 1, 2005, the population in North Carolina totaled 8,683,242. This reflected a 7.9 percent increase since 2000, well above the national growth rate of 5.33 percent. North Carolina's growth rate is the ninth fastest in the nation.[21]

In brief, the North Carolina population can be characterized as follows:[22] the results of the 2006 American Community Survey as reported by the U.S. Census Bureau show that 70.3 percent of the North Carolina population reported white as their race; 21.4 percent reported race as Black or African American (which is almost twice the number reported in the United States as a whole); 1.8 percent reported race as Asian; and 1.1 percent reported their race as American Indian. Approximately, 7 percent reported being Hispanic or Latino regardless of race.[23]

Further, the U.S. Census Bureau reported that approximately 82 percent of the population in North Carolina had at least a high school degree, and 24.8 percent had at least a Bachelor's degree, which is about par with what the rest of the nation reports. North Carolina has four large military bases and many members of the military remain in the state after retirement. In 2006, 11.3 percent of the North Carolina population reported being a civilian veteran (that is over 18 years of age who has served, but is not now serving, on active duty). Military retirees are a potential pool of workers for the public mental health, developmental disabilities, and substance abuse services system.

The U.S. Census Bureau estimated that 14.7 percent of North Carolina's population (approximately 1,261,000 people) lived in poverty in 2006. This represents approximately 10.7 percent of families in North Carolina population that live below the official federal poverty level.[24] This represents a decrease in the percentage of families living in poverty from 11.7 percent in 2005.[25]

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[21] Dept. of Geography and Earth Sciences, The University of North Carolina at Charlotte. See: www.ncatlasrevisited.org.
[22] Note that differences in population statistics and projections are due to use of different baseline data and/or methods of calculation used by various organizations. Regardless the overall effects reported are the same.
[23] Go to: http://factfinder.census.gov/. Select Fact Sheet in left column, select 2006 and select North Carolina for the facts reported above.
[24] See: www.census.gov/hhes/www/poverty/poverty.html.
[25] See: www.census.gov/prod/2007pubs/acs-08.pdf.

In 2005, the five most populous counties (in order from most populous to least) were: Mecklenburg, Wake, Guilford, Forsyth, and Cumberland. The five least populous counties (from least to most populous) were: Tyrrell, Hyde, Camden, (all east coast counties), Clay (a western county), and Jones. A map of urban and rural counties and persons per square mile by county, based on population projections for 2006, is shown on the following page.

North Carolina's Population Trends

Trends in North Carolina's population indicate both the probable future demands for services as well as the probable availability of workers. Such data are necessary to guide workforce development planning and monitoring.

The population of the United States is projected to be 400 million in 50 years. By 2014, the projected population in North Carolina will be 9.5 to 10 million, up from 8.5 million in 2005. The United States Census Bureau has projected that North Carolina will become the seventh most populous state by 2030, with over 12.2 million residents.

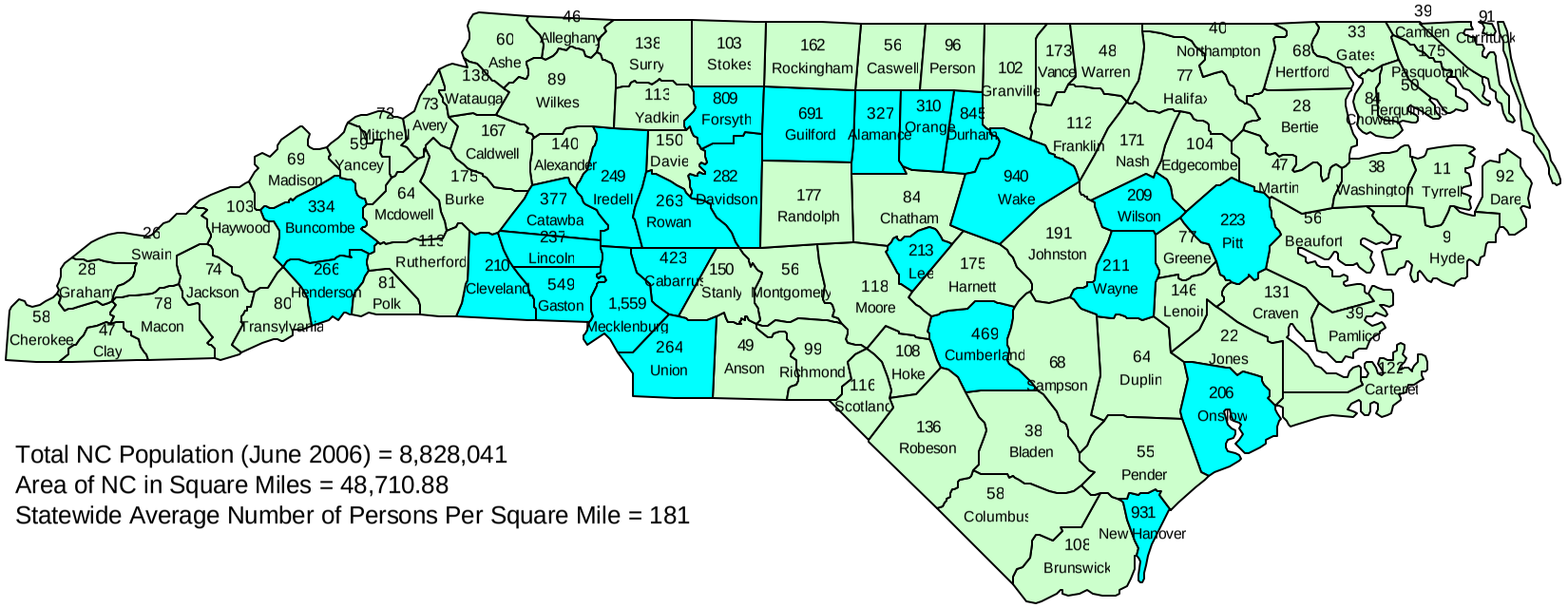
Reasons for North Carolina's growth are numerous, as suggested by the Employment Security Commission.[26] North Carolina is attracting many people from other parts of the nation due to its excellent strategic position along the eastern seaboard, its robust economy, work and educational opportunities, its weather and diverse geography—coast line, mountains, farmlands – as well as its healthcare and biotechnology centers. Consequently, there is continuous movement of retirees and the workforce from the Deep South and from the North or North-East.

Further, North Carolina is in the center of the nation's infrastructure; we have the second most paved roads among states in the country. Charlotte is ninth in the world in banking. There are large pockets of artisan shops throughout rural North Carolina that form a strong part of North Carolina's economy. In addition, North Carolina is experiencing growing globalization.

Another major change in North Carolina's population is due to growth in its Asian and Latino populations and related demand for services. Though Asians and Hispanics currently make up less than 10 percent of the North Carolina population, it is expected that migration into the state of these populations will continue. Between 1990 and 2002, the Latino population increased by over 368,000 with the largest increases in Mecklenburg and Wake counties. The statewide Latino population in 2004 totaled 600,913, about 7 percent of the state's total population. The NC Atlas Revisited reports that North Carolina is a magnet for population growth from both international and inter-regional population shifts. "We are destined to become a highly diverse community."[27]

[26] See: http://www.ncesc.com/lmi/occupational/occupationMain.asp.
[27] See: Excerpt from "The Changing Face of North Carolina" found on http://www.ncatlasrevisited.org/homefrm.html.

Urban and Rural Counties and Persons Per Square Mile in NC By County 2006



Total NC Population (June 2006) = 8,828,041
Area of NC in Square Miles = 48,710.88
Statewide Average Number of Persons Per Square Mile = 181

Persons Per Square Mile
- < 200 (Rural, 75 counties)
- = 200 (Urban, 25 counties)

Population: NC State Demographics Unit website, July 2006 Population Projections (12/6/06).
County Area: US Census Bureau 2006 Quick Facts (http:/quickfacts.census.gov/qfd/states/37/).
Urban/Rural: NC Rural Economic Development Center defines urban and rural based on population density as of the 1990 Census of Population. Rural counties contain fewer than 200 persons per square mile. Urban counties contain 200 or more persons per square mile (http://www.ncruralcenter.org/databank/). Counties in this table are defined based on the same population density criteria using July 2006 population projections.
Analysis and Map: NC DMH/DD/SAS, Quality Management Team, 10/2/07.

North Carolina's Workforce

In 2006, the number of people over 16 years of age in the North Carolina labor force was approximately 4,520,961. The median household income was about $42,625. The five counties with the lowest median household income (in 2003 dollars) are: Tyrrell, Bertie, Warren, Halifax, and Robeson (ranging from $25,843-$26,870). The five counties with the highest median household income (in dollars in 2003) are: Wake, Union, Mecklenburg, Cabarrus, and Camden (ranging from $46,409-$57,040).[28]

There were 59 counties in North Carolina with unemployment rates at or below 5 percent in 2006.[29] However, counties that traditionally have emphasized manufacturing and agriculture have experienced higher rates of unemployment due to loss of jobs as industries closed or relocated. Often, problems of depression or substance abuse affect dislocated workers.

Whether it is loss of jobs, or increased competition for existing jobs, training is needed to enable potential workers to develop new skills and qualify for different employment. Some new industries may demand a more highly trained workforce requiring skills such as critical thinking and problem solving. Some require development of skills in working with people. As stated by Martin Lancaster, president of the North Carolina Community College system, this shift in North Carolina's economy has been from "farm" to "factory" to "pharmacology".[30] As this shift continues to occur, it is timely and beneficial to bring to the forefront the need and planning efforts for an expanded workforce in mental health, developmental disabilities and substance abuse services.

North Carolina Workforce Trends

The Employment Security Commission and the UNC School of Government report a number of trends that are evident in the overall workforce affecting all occupations. Examples are:

- The "graying" of the workforce:
    - Life expectancy is increasing.
    - Sixty-five is the retirement age for many industries and there are no incentives to continue working after 30 years of employment.
    - There is a 141 percent projected increase in the number of retirees in the North Carolina Retirement System between 2003 and 2022.
    - In 2001, almost 50 percent of knowledge workers in government were 45 years of age and older.
- Dissatisfaction in lower paying jobs:
    - There is an increasing "churning" among workers within many industries. For example, a particular cashier may have four different cashier positions at four different places-of-work within one year. This "churning" can create the illusion of many job openings, though it is an indication of high rates turnover.

[28] See: http://quickfacts.census.gov.
[29] Employment Security Commission of NC, October 2006.
[30] http://www.ncccs.cc.nc.us/External_Affairs/President/presinfo.htm.

- Adult children are remaining in their parents' home and returning to their parents' home even after moving out for a while. In part this is due to low end jobs that don't pay enough for youth to afford to be on their own. Furthermore, the need for healthcare drives this prolonged time at home and in higher education.
- There are fewer and fewer "starter" jobs that help teach young people the soft job skills such as the importance of showing up on time and delivering customer service. Also, young people often need to learn work ethics, which they are currently not bringing to the job.
- After obtaining degrees, new graduates often make decisions about jobs based on the amount of debt they have.
- Due to the high turnover in bottom level positions, there is a fear among industries that if they train younger workers then they are essentially training them to leave.

- Higher levels of stress:
  - Stress levels among workers are increasing. Traditional rules on how people ought to behave with each other are breaking down and people don't know what to expect from one another. Workers and managers alike face and cope with this stress.
  - The role of a manager is more complex and stressful as there are increasingly different generations of workers in the workforce at one time, each with different characteristics, values, goals and work ethics.[31]
- Evolution of the types of jobs:
  - North Carolina is currently experiencing an evolution in manufacturing. While we are losing jobs and industries in traditional "smokestack" or "heated" manufacturing, we are gaining jobs and industries in types of manufacturing that are "clean" involving the use of technology and advanced skills. Robotics, specialized welding, tool and dye are all strong parts of North Carolina's economy.

Projections about the Labor Market and Workforce Environment

According to the Labor Market Information Division of the Employment Security Commission, North Carolina is expected to add nearly 700,000 jobs between 2004 and 2014. [32]

> "North Carolina's economic future resonates strength and continued growth…. North Carolina is predicted to outperform the nation as well… The number of individuals employed in the state is expected to increase from 4.1 million [in 2004] to 4.8 million [in 2014] – a growth of nearly 17 percent. In comparison, United States' employment is projected to increase 13 percent …"[33]

[31] See appendix B for brief description of the four generations.
[32] See: http://www.ncesc.com/lmi/occupational/occupationMain.asp
[33] See: ESC News Release on February 26, 2007 at http://www.ncesc.com

Projections about the Labor Market[34]

The Employment Security Commission further projects that in 2014 of the top 20 occupations in North Carolina, 12 will be healthcare related.[35] These reflect new jobs in occupations such as medical assistants, biomedical engineers, home health aides, child/family/school social workers, nursing aides/orderlies/attendants, paramedics, physician assistants, personal care aides, medical records and health information technicians, and psychiatric technicians.

Table 3. Projections of new jobs in health care occupations for 2014

Healthcare Technicians		**Health Care Support**	
2004	2014	2004	2014
195,000 people	257,000 people	116,000 people	158,000 people

Healthcare support occupations (e.g., medical records and health information technicians) will likely increase the most (at 3.13 percent per year); the fastest percentage growth is expected to be in Bladen, Robeson, Scotland, and Hoke counties. Other rapidly growing occupations include post-secondary teachers and engineers.

Major issues in these fields are:

- Careers in education and health services have one of the highest turnover rates and the South has the highest turnover rates according to the Bureau of Labor Statistics.[36]
- Knowledge in any of these fields is often obsolete after two years of graduation.
- As older workers retire, they take with them considerable knowledge that is often not passed on to those who take their places.
- A major challenge for organizations and agencies is keeping employees' knowledge and skills up to date.
- A major question is who is responsible for such training.

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[34] The labor market is comprised of various industries that are classified in the following ways:

- The Standard Occupational Classification system (SOC) classifies all workers into one of over 820 occupations requiring similar job duties, skills, education, or experience.
- The Classification of Instructional Programs (CIP) presents a taxonomy of instructional program classifications and descriptions that can be cross walked with the SOC.
- The O*NET system serves as the nation's primary source of occupational information, providing comprehensive information on key attributes and characteristics of workers and occupations.

There is a well established process by which new industries are introduced into the SOC system. The SOC is updated every five years and the updates are conducted through surveys with employers. A new SOC is expected in two years. There is also an important relationship between the SOC and the CIP (one may first identify an occupation within the SOC and then use the SOC number to find the corresponding CIP code which lists the various educational degrees or programs required for that occupation). Business and industry drive the curricula offered especially at community colleges. This process unfolds in conjunction with the Chambers of Commerce, the 24 workforce development boards (WDB) throughout the state of North Carolina, and the Department of Commerce.

[35] The Labor Market Information Division of the Employment Security Commission makes projections by comparing historical data sets for industries to industry-occupation matrices. See www.ncesc.com/lmi/occupational/occupationMain.asp.

[36] http://www.bls.gov/schedule/archives/jolts_nr.htm#2007

Current Workforce for the Public MH/DD/SA Services System

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the largest division in the N.C. Department of Health and Human Services (DHHS) with over 12,000 employees working throughout the state at its headquarters in Raleigh, four large psychiatric hospitals, three developmental disabilities centers, three alcohol and drug abuse treatment centers (ADATCs), three neuro-medical centers, and two residential programs for children.

The major of the Division's workforce is in the state operated facilities. The role of the facilities and the populations they serve are changing. One example is the change currently being implemented in the alcohol and drug abuse treatment centers (ADATCs). While LMEs and providers have demonstrated some success in increasing capacity in community-based substance abuse programs, they have not developed adequate community-based detoxification services, particularly for individuals with significant medical complications. In recognition of that reality, the model for the ADATCs is being changed from 28-day rehabilitation facilities, to providers of acute and sub-acute detox services for particularly challenging individuals.

Since 2006, the Division has begun the conversion of the O'Berry Center, the Black Mountain Center and the Special Care Center into neuro-medical centers. These centers are designed to provide specialized medical, mental health and developmental services to individuals with complex, multiple neuro-cognitive and medical needs.

In addition, considerable progress has been made with the construction of the new Central Regional Hospital at Butner with anticipated occupancy in the summer of 2008. The new hospital will serve patients currently served at Dorothea Dix Hospital and the John Umstead Hospital. The General Assembly recently approved special indebtedness funding to replace the other two hospitals in Goldsboro and Morganton in the next five years.

Beyond the Division, the workforce in the public mental health, developmental disabilities substance abuse services system is composed of the staffing of local management entities (LMEs) and all providers endorsed by the LMEs or with whom LMEs contract for services.

The North Carolina Administrative Code governs the Division and its services and specifies staff definitions, applicable credentials and qualifications. See a copy of these specifications as defined in 10A NCAC 27G .0104 in appendix D. The categories of staff that are noted in this rule and in the approved Medicaid service definitions include associate professional, paraprofessional and qualified professional, as well as licensed professionals (psychiatrist, psychologist, clinical social worker, nurse, and professional counselor) and certified substance abuse staff. See appendix A for additional information about licensed professionals in North Carolina regarding licensing boards and governing statutes and rules. Requirements for supervision are also defined. The code also allows for the establishment of a competency-based employment system for qualified professionals, associate professionals and paraprofessionals.

Definitions and Language

For purposes of this initiative, the term "workforce" includes individuals in training or currently employed to manage or provide health promotion, prevention, and treatment services and supports for persons with mental health conditions, or substance abuse or substance abuse disorders, or developmental disabilities, or co-occurring disorders. Individuals in the workforce may have graduate training, associate's or bachelor's degrees, high school diplomas or less formal education. In addition, consumers receiving services and supports and their family members are recognized as having critical roles in caring for themselves and each other, whether informally or more formally through organized peer- and family-support services. Definitions of other commonly used terms are shown below.

Community services and supports	Refers to all services provided in the community for any of the populations served.
State-operated services	Refers to the services provided in the facilities operated by the Division including psychiatric hospitals, alcohol and drug abuse treatment centers, developmental centers, residential programs for children, and neuro-medical treatment centers.
Clinical services	Active direct treatment and habilitation, such as counseling, medication management, diagnostic assessment and detoxification. These services are primarily provided in an office or clinical setting, including in state-operated facilities. Clinical service roles require a formal degree in a human service or medical field, including qualified professionals or associate professionals.
Direct support services	Services typically provided in the homes of families and in the community. These services enable consumers, whether adults or children, to live in community settings and to participate within the environment of their own or their family's culture. The workforce of direct support service roles predominantly consists of bachelor's level employees and individuals with high school diplomas or GED diplomas, otherwise identified as paraprofessionals.
Direct support workers	Traditionally referred to the workforce providing services and supports for persons with developmental disabilities. Currently, direct support workers play a vital role in the lives of people with developmental disabilities, people with mental health needs, people with substance abuse challenges, and their families, as well as members of the aging population. Direct support workers assist people with a wide range of activities such as help with maintaining a home, finding work, transportation, making important decisions, taking medications, learning new skills, personal care, and connecting with other people and activities.[37]

[37] See Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007.

Direct support services are also compatible with the system of care approach used in the field of children's mental health. The combination of direct support services with traditional clinical services have been found to be the most successful for children with challenging needs as evidenced by Multi-Systemic Therapy, an evidence-based practice, or Intensive In-Home service. Clinicians provide consistent and frequent supervision to ensure that direct support workers are prepared to meet the challenges that are inherent in their jobs from understanding basic theories of behavior, to possessing strong listening and communication skills, and other skills as well as support for practical aspects of the job such as scheduling and coverage.

While other health and human service providers, such as primary care providers, emergency room staff, and others have major roles in responding to the needs of consumers of public mental health/developmental disabilities/substance abuse services, those segments of the workforce are not addressed in this initiative.

Data Analysis

To further identify and analyze the current workforce of public mental health, developmental disabilities substance abuse services system, the Data and Information Subcommittee asked the following questions:

- What are the career levels within the system?
- Is the current workforce stable at every career level?
- Does it provide high quality services for all service definitions?
- Is the workforce distributed equitably across the State?
- Is the workforce cooperative with and respected as an essential part of the State's health care workforce?
- Is there access to reasonable career ladders within the workforce?
- Is the workforce adequately trained through a variety of ongoing training resources?
- Does the workforce represent a cost effective use of county, state and federal resources?

The subcommittee sought information about the current workforce with the intention to compare the workforce needs against currently available staff and their skills. Ideally, the following information would be available for staff of service providers, of LMEs, and the state-operated facilities and central office of the Division: number of positions by title, number of vacancies, wage range, turnover rate, education/training and experience, and demographics of managerial, administrative, clinical and direct support staff.

Unfortunately, such data are not readily available or maintained in a cohesive, consistent, user friendly, and/or accessible way. Even the attempt to identify this workforce through the Employment Security Commission database was unsuccessful, because providers use various job classifications that do not match the job titles used by LMEs, the Office of State Personnel, or the Employment Security Commission. This causes a major challenge when trying to identify and analyze the current workforce as well as plan for a future workforce. Instead, the subcommittee focused on available information from other sources.

Changes in Healthcare Workforce and Management

As the public mental health, developmental disabilities and substance abuse services system evolves, managers and professionals within those organizations must develop new skill sets. In the past, area programs were both a provider of services and the manager of services responsible for ensuring adequate service capacity within their catchment areas. To accomplish this, they provided services directly or contracted with other service providers. These contractual relationships provided a mechanism for coordinating services and providing oversight. Leadership of the organization was often provided by senior therapists who were promoted into management positions.

As the public system transforms, business models are evolving. Area programs have divested services and have transformed into local management entities (LMEs). LMEs have assumed new functions, as outlined in an annual performance contract with DHHS, including governance, financial and business operations, claims management, information technology, service management, endorsement of providers, and monitoring system performance.

The need for new business relationships has emerged and there is an ever increasing need for professionally trained business managers. The traditional career path of moving from service provider to manager can no longer be assumed. The skill set that makes one an outstanding service provider may not necessarily provide the requisite management skills to make an outstanding manager. There is an increasing need for professionally trained health care and business managers as well as additional management training for LME staff to ensure they have the right skills to successfully fulfill their new LME functions.

Non-Licensed and Non-Certified Workers – Direct Support Workers

In North Carolina, as in the rest of the nation, the demand for direct support workers is growing rapidly. Several factors are responsible: a) growth in and changing demographics of the U.S. population, b) increased demand for services and c) high rates of turnover among existing direct support workers. Over the period 2004 to 2014, the Employment Security Commission projects that several direct support worker occupations will be among the top ten fastest growing occupations in the state. Jobs for home health aides are expected to increase by 48.3% over this period (16,680 growth openings); nursing aides, orderlies and attendants by 27.8% (13,150 total growth openings); and personal and home care aides by 49.5% (9,300 growth openings). Over the decade these three occupations are expected to create a total of just under 40,000 job openings.

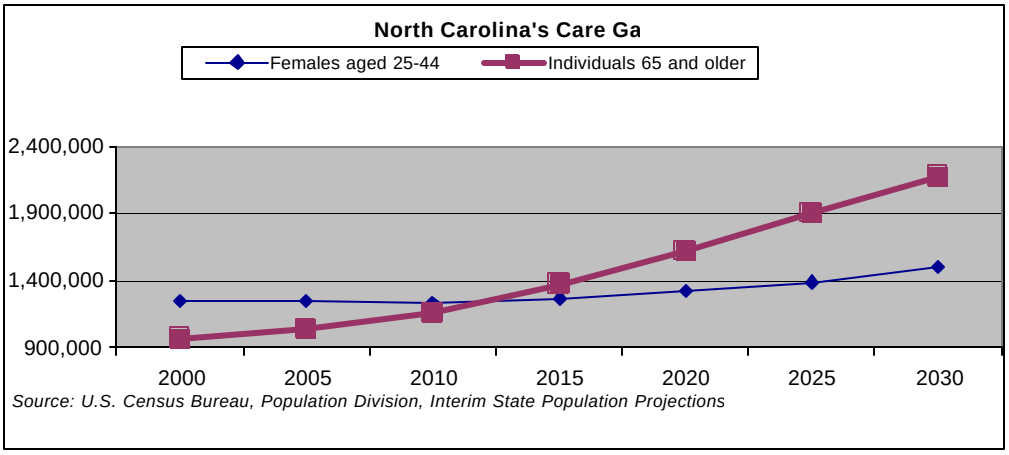
In developmental disabilities, the anticipated increase in demand for services will be 37%, or an estimated total number of 8,400 additional service recipients by the year 2020. For this group of people alone, growth will require an additional 11,000 new direct support positions between now and 2020 (or about 800 new full time equivalent positions each year if the growth is distributed evenly over the time period).[38] At current turnover rates[39], an additional 14,329 direct support workers will need to be hired between now and 2020 (1023 per year) and unfilled positions are

[38] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long Term Care Policy, 2006.

[39] Underestimated at 41% based on Test, D. et al., North Carolina direct support professionals study: Final report. Charlotte: University of North Carolina at Charlotte, 1999.

estimated to require another 3,539 workers. Roughly, 18,780 new direct support workers will be required just to support service recipients in the developmental disabilities service system between now and 2020.

Figure 1 illustrates that while the population of people over the age of 65 in North Carolina is growing at a rapid pace, the population group (women aged 25 – 44) that has traditionally provided the direct care to older Americans is expected to increase only slightly over the same period. This relationship is sometimes referred to as "North Carolina's care gap". Furthermore, as baby boomers begin to age, and as demand for care increases, community human services employers will be in intense competition with other service sector employers (such as retail and travel) as well as other employers within the community human services industry.



Licensed and Certified Professionals

Information was obtained about licensed and certified professionals in North Carolina from the following sources. Not all data was available from these sources in a format that enabled further analysis or mapping. Additional information is available on other medical professions such as nursing professions, physical therapists, dentists and pharmacists from the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.[40]

- North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, UNC-CH, with data derived from the North Carolina Medical Board and North Carolina Medical Society, 2006
- North Carolina Psychology Board, Cecil G. Sheps Center for Health Services Research, UNC-CH, with data derived from the North Carolina Psychology Board, 2006
- North Carolina Board of Licensed Professional Counselors, December 2006
- North Carolina Board of Nursing, November 2007
- North Carolina Social Work Certification and Licensure Board, February 2007

[40] Cecil G. Sheps Center for Health Services Research at UNC-CH, Trends in Licensed Health Professions in North Carolina 1979-2005, June 2007.

- North Carolina Substance Abuse Professional Practice Board, January 2007
- North Carolina Marriage and Family Therapy Licensure Board, March 2007
- American Association of Pastoral Counselors, March 2007

Maps[41] locating the following mental health and substance abuse professionals by county across the state are provided in the companion statistical report. Although the individuals on record from each of these sources hold a current license or certification, it is not known how many are actually practicing and/or in an administrative position. Further, it is not known whether the county data is the county of residence and/or practice. Most importantly, it is unknown how many of each profession work in the public mental health, developmental disabilities and substance abuse services system versus private practice.

Substance Abuse Professionals

- Certified Substance Abuse Counselors
- Licensed Clinical Addiction Specialists
- Certified Clinical Supervisors
- Certified Criminal Justice Addiction Professionals
- Certified Substance Abuse Prevention Consultants
- Certified Substance Abuse Residential Facility Directors

Mental Health Professionals

- Psychologists (Doctoral Level)
- Psychological Associates (Masters Level)
- Licensed Clinical Social Workers (LCSW)
- Provisionally Licensed Clinical Social Workers (P-LCSW)[42]
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)
- Marriage and Family Therapy Associates (MFTA)
- Fee-Based Practicing Pastoral Counselors
- General Psychiatrists
- Child Psychiatrists
- Other Psychiatrists (forensic, geriatric, psychoanalysts)
- Licensed Nurses (RNs, NPs and LPNs)

However, some conclusions can be drawn by studying the maps on the following pages. These maps show the estimated number of individuals with either mental health or substance abuse disorders per the number of licensed or certified professionals for each county.[43]

[41] Psychiatrists, Licensed Mental Health Professionals, Certified/Licensed Substance Abuse Professionals, And Persons Needing Mental Health Or Substance Abuse Services In North Carolina By County, 2006, Prepared by Quality Management Team, Community Policy Management Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services, March 2007.

[42] Although information was sought on all provisionally licensed professionals, the only information available was for provisionally licensed clinical social workers (P-LCSW).

[43] See appendix C for a description of calculations of estimating the number of persons in need of services per licensed professionals.

Maps were not created for either associate professionals or direct support workers since there is no single or multiple sources of complete data. What is known is that direct support or direct care workers provide an estimated 70 to 80 percent of the paid hands-on long term care and personal assistance for Americans who are elderly, chronically ill or live with disabilities.[44]

In addition to the factors of population growth in North Carolina and the aging of the population and the workforce, and even assuming the prevalence of individuals with mental health or substance abuse problems remain steady, the maps clearly show the following:

1. There is currently an inadequate number of mental health and substance abuse professionals to meet the demand for services.

2. There is a chronic mal-distribution of mental health and substance abuse professionals across the state.

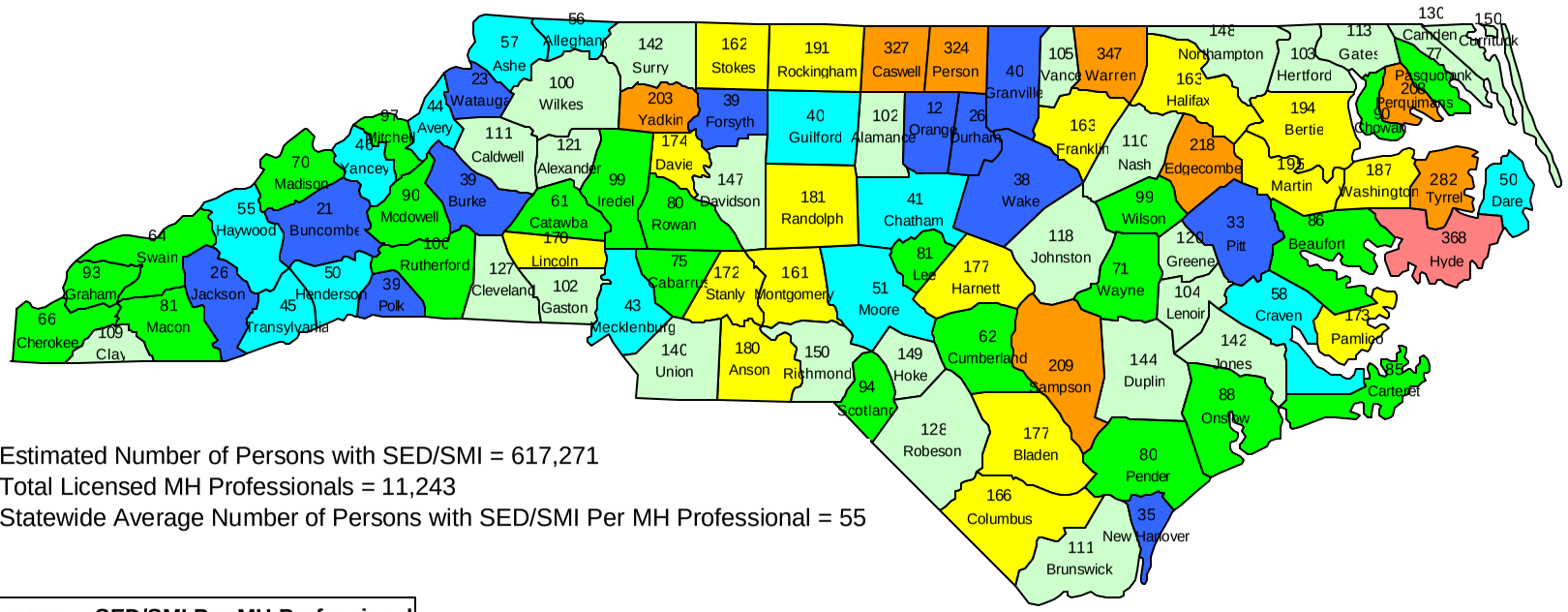
As the North Carolina Institute of Medicine reports, there is an acute primary healthcare provider shortage and mal-distribution across the state.[45] That report addresses the urban/rural disparity well noting that two significant factors that affect a provider's choice of location of practice are economic potential and lifestyle preferences. That report also suggests a variety of incentives to encourage providers' moving to rural areas, such as scholarships, loans, and loan repayment.

[44] Institute for the Future of Aging Services, American Association of Home and Services for the Aging (AAHSA), Step Up Now for Better Jobs and better Care: The Evaluation of a Workforce Intervention for Direct Care Workers, Executive Summary, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. See: http://www.bjbc.org

[45] North Carolina Institute of Medicine, *Providers in Demand: North Carolina's Primary Care and Specialty Supply*, June 2007.

Estimated Number of Persons with SED/SMI Per Licensed Mental Health Professional in NC By County 2006

[Practicing Psychologists, Psychological Associates, Clinical Social Workers, Professional Counselors, Marriage and Family Therapists, and Fee-Based Practicing Pastoral Counselors]



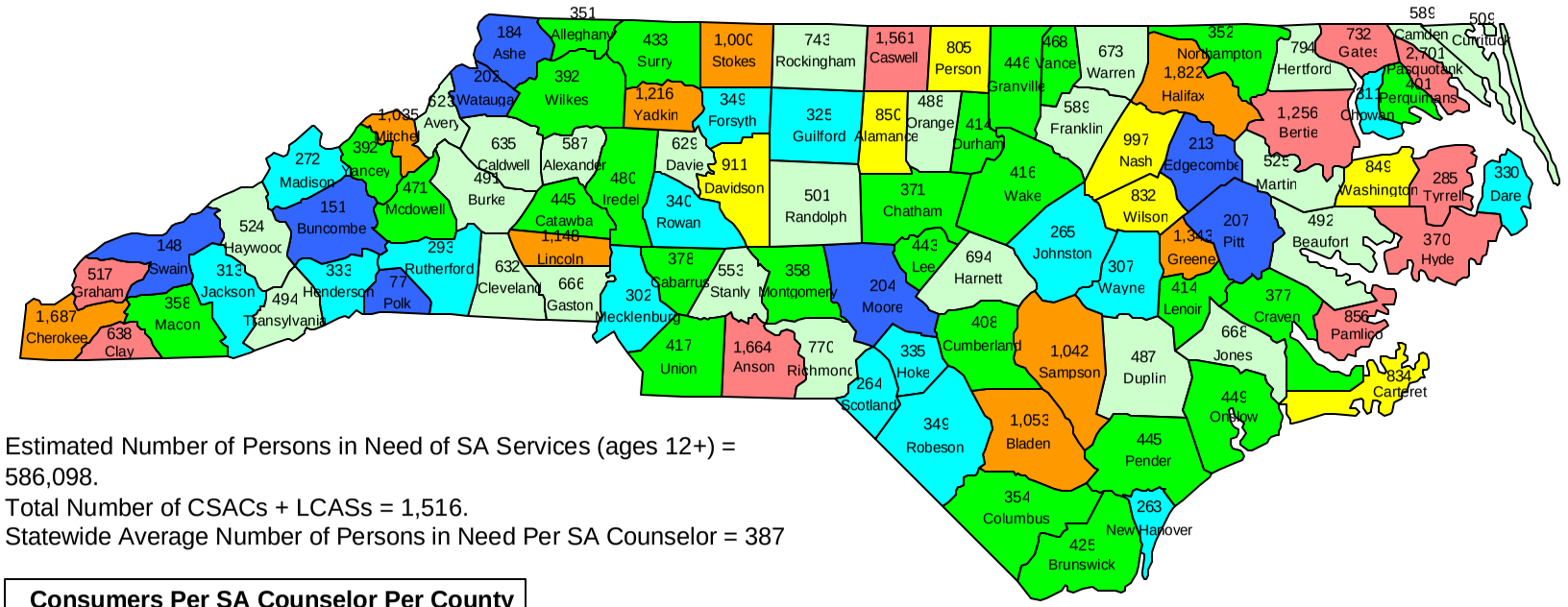
Estimated Number of Persons with SED/SMI = 617,271
Total Licensed MH Professionals = 11,243
Statewide Average Number of Persons with SED/SMI Per MH Professional = 55

Persons w SED/SMI Per MH Professional	
No MH Professional*	(1 county)
1 to 39	(12 counties)
40 to 59	(13 counties)
60 to 99	(23 counties)
100 to 159	(26 counties)
160 to 199	(17 counties)
200 to 347	(8 counties)

MH Professionals Data: Psychologists - NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, UNC at Chapel Hill, 12/6/06. LCSWs - NC Social Work Certification and Licensure Board, 2/15/07. LPCs - NC Board of Licensed Professional Counselors, 12/11/06. LMFTs - NC Marriage & Family Therapy Licensure Board, 3/1/07. FBPPCs - American Association of Pastoral Counselors, 3/6/07. **Population Data**: NC State Demographics Unit, July 2006 Population Estimates. **Prevalence Rates for SED/SMI**: Prepared for CMHS by NRI/SDICC, 8/29/06 (for the MH Block Grant). Children with Serious Emotional Disturbance, ages 9-17, by State, 2005 = 12%. This percentage was applied to all children. Number of Persons with Serious Mental Illness, ages 18 and older, by State, 2005 = 5.4%. **Analysis and Map**: NC DMH/DD/SAS, Quality Management Team, 3/1/07.

* For red counties with "No MH Professional", the numbers represent estimated persons with SED/SMI in the county.
Blue colors = top quartile, Green colors = middle two quartiles, Yellow & Orange & Red = bottom quartile

Estimated Number of Persons in Need of Substance Abuse Services Per SA Counselor (Total of Certified Substance Abuse Counselors & Licensed Clinical Addictions Specialists) In NC By County 2006



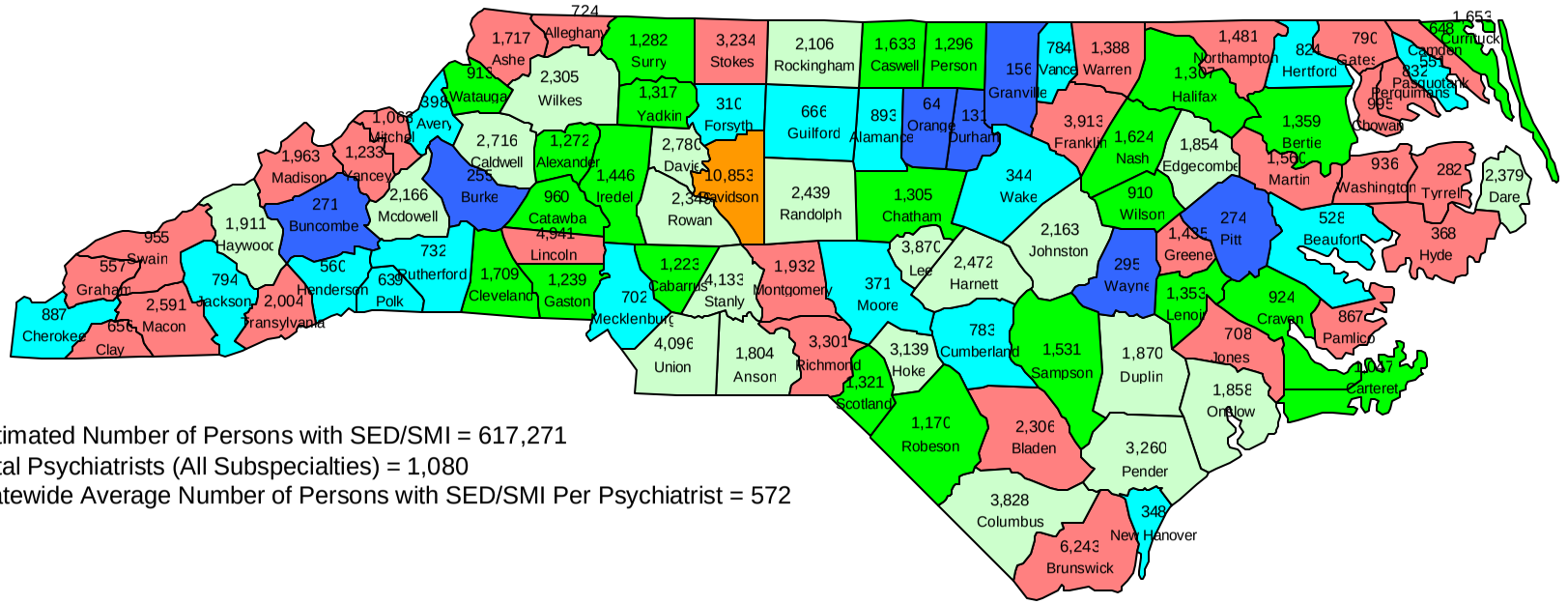
Estimated Number of Persons in Need of SA Services (ages 12+) = 586,098.
Total Number of CSACs + LCASs = 1,516.
Statewide Average Number of Persons in Need Per SA Counselor = 387

Consumers Per SA Counselor Per County	
No SA Counselor*	(10 counties)
1,000 to 1,822	(9 counties)
800 to 999	(7 counties)
480 to 799	(24 counties)
350 to 479	(26 counties)
260 to 349	(16 counties)
1 to 259	(8 counties)

SA Counselor Data: NC Substance Abuse Professional Practice Board, January 2007.
Population Data: NC State Demographics Unit, July 2006 population estimates.
NC Prevalence Data: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2003 and 2004. Persons with a SA Disorder: Ages 12-17 (7.24%), Ages 18-25 (17.30%), Ages 26+ (6.26%), Overall Ages 12+ (7.79%).
Analysis and Map: NC DMH/DD/SAS, Quality Management Team, January 2007.

* For red counties with "No SA Counselor", the numbers represent estimated persons in need of SA services in the county.
Blue colors = top quartile, Green colors = middle two quartiles, Yellow & Orange & Red = bottom quartile

Estimated Number of Persons with SED/SMI Per Psychiatrist (All Subspecialties) in NC By County 2005



Estimated Number of Persons with SED/SMI = 617,271
Total Psychiatrists (All Subspecialties) = 1,080
Statewide Average Number of Persons with SED/SMI Per Psychiatrist = 572

Persons In Need Per Psychiatrist	
No Psychiatrist*	(30 counties)
5,000 to 10,900	(1 county)
1,800 to 4,999	(21 counties)
900 to 1,799	(23 counties)
300 to 899	(18 counties)
64 to 299	(7 counties)

Psychiatrists Data: NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of NC at Chapel Hill, with data derived from the NC Medical Board and NC Medical Society, 2006. **Population Data**: NC State Demographics Unit, July 2006 Population Estimates. **Prevalence Rates for SED/SMI**: Prepared for CMHS by NRI/SDICC, 8/29/06 (for the MH Block Grant). Children with Serious Emotional Disturbance, ages 9-17, by State, 2005 = 12%. This percentage was applied to all children. Number of Persons with Serious Mental Illness, ages 18 and older, by State, 2005 = 5.4%. **Analysis and Map**: NC DMH/DD/SAS, Quality Management Team, 3/8/07.

* For red counties with "No Psychiatrist", the numbers represent estimated persons with SED/SMI in the county.
[Includes active, instate, non-federal, non-resident-in-training physicians by self-reported primary specialty area, licensed in NC as of October 31, 2005]
Blue colors = top quartile (25%), Green colors = middle two quartiles (44%), Orange & Red = bottom quartile (31%)

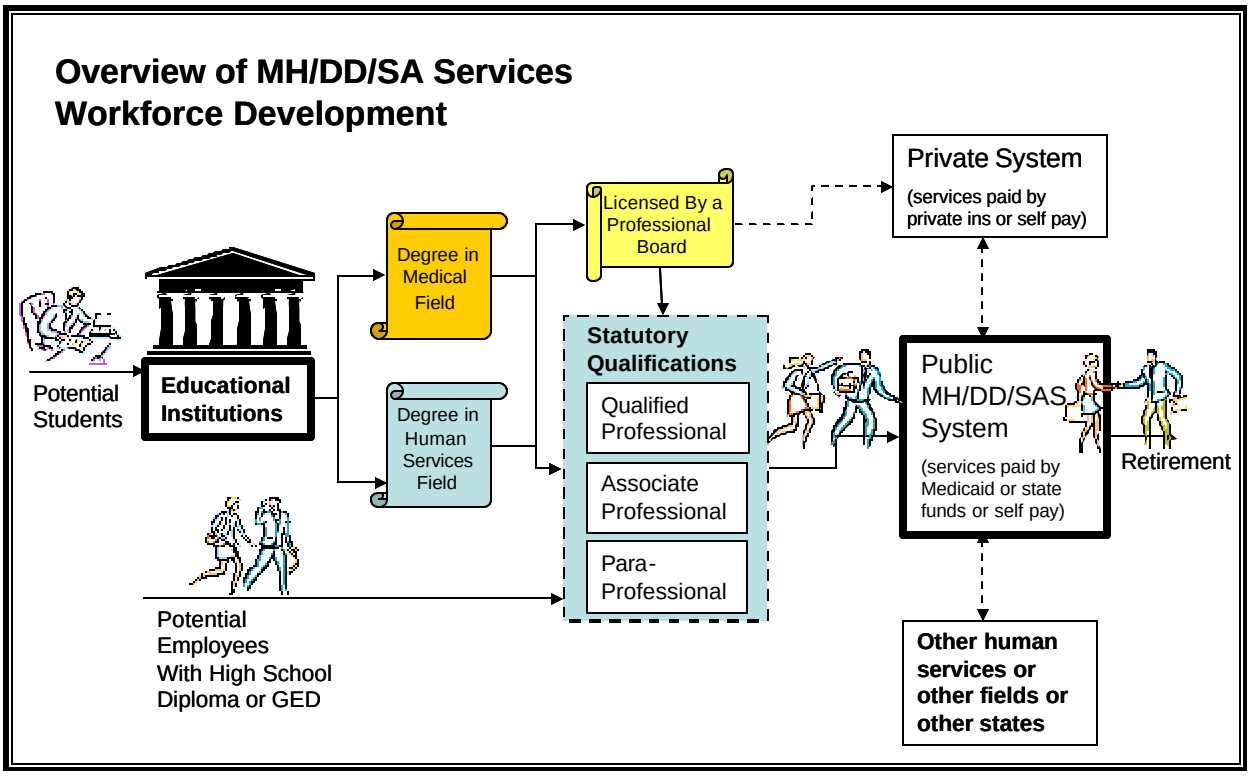
Overview of the Findings:

Workforce Issues and Potential Solutions

North Carolina is experiencing significant current and projected changes in its population and workforce. Relevant to this workforce development initiative, there are indications of significant shortages in healthcare in general, and in community human services in particular. A well-constructed strategy is essential to prepare for that future with a continuous supply of highly skilled, competent workers both at the professional and direct support levels as well as to meet current needs.

Improving the status of the workforce is a complex situation that involves many stakeholders: educators, curricula developers, career advisors, trainers, human resource managers, recruiters, public relations, managers of services, providers of services, supervisors and line managers, employees, consumers, and future workers. Each has particular needs and preferences. Collaboration is necessary to build a system that works to everyone's advantage.

The following diagram serves to illustrate the many components of this complex endeavor.



Universal Workforce Problems in Mental Health, Developmental Disabilities and Substance Abuse Services and Supports

Concerns about the current and future workforce in the fields of mental health, substance abuse and developmental disabilities have come to the forefront at the federal level, among universities, professional groups and advocacy groups, in addition to the state government level.

1. The Annapolis Coalition on the Behavioral Health Workforce prepared a Workforce Development Plan[46] for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in which they identified a number of problems that affect the entire behavioral healthcare field.

2. For a number of years, the Research and Training Center of the University of Minnesota has studied workforce issues pertaining to workers who provide direct care for individuals with developmental disabilities.[47]

3. Similar workforce issues have also been identified in the field of long-term care as reported by the Paraprofessional Healthcare Institute.[48]

The findings of these organizations are shown in table 5. Clearly, there is consistency in their findings regarding the types of issues facing the workforce for community services and supports.

Recognizing these problems, the federal Centers for Medicare and Medicaid funded a National Resource Center on the Direct Support Workforce to provide technical assistance and gather national information and data regarding the crisis in the direct support workforce through the United States.[49]

In June 2007, the North Carolina Institute of Medicine (IOM) published five fact sheets of their findings regarding the future demand for healthcare in North Carolina. Many of these findings are applicable to the workforce serving consumers of mental health, substance abuse and developmental disabilities services and supports. Applicable findings concluded:

- Current provider growth is insufficient to meet North Carolina's growing healthcare needs.

- North Carolina can address the anticipated provider shortage by developing new models of care or increasing provider supply.

- Certain areas of North Carolina are facing an acute shortage of healthcare providers.

[46] The Annapolis Coalition on the Behavioral Health Workforce, 2007. See http://www.annapoliscoalition.org/.
[47] See: http://www.rtc.umn.edu/dsp.
[48] Paraprofessional Healthcare Institute, see www.paraprofessional.org and www.directcareclearinghouse.org.
[49] See http://www.dswresourcecenter.org.

- North Carolina lacks primary care providers and certain specialists in parts of the state, noting in particular a shortage of child psychiatrists and varied access to adult psychiatrists, to prenatal and delivery services, and to general surgeons.

- Minorities are underrepresented in the health professions in North Carolina and more multilingual and multicultural providers are needed.

Two of the North Carolina Institute of Medicine's priority recommendations involve the Division of MH/DD/SAS. Those involving the Division are:

> "Recommendation 4.6: The NC General Assembly and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should provide funding to targeted rural communities to establish new models of care to service public patients in rural and underserved communities.
>
> "Recommendation 4.7: The NC General Assembly, public and private insurers, and payers (including, but not limited to, the State Health Plan, NC Division of Medical Assistance, and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services) should pay for a) psychiatric consultations for primary care providers and other clinicians either through face-to face consultations or telemedicine; and b) services provided by primary care providers to patients who have been diagnosed with a psychiatric diagnosis…." [50]

[50] North Carolina Institute of Medicine, Providers in Demand, pp. 85-86.

Table 5. Workforce issues affecting community human services identified at the national level

Annapolis Coalition on Behavioral Health Workforce	Paraprofessional Healthcare Institute	Research & Training Center, University of Minnesota
Consumerism & Demand for Services		
• A rise in consumerism. • Consumers and families receive little educational support. • Consumers and families' experience does not inform the workforce. • The diversity of the workforce doesn't match the diversity of those served.	• An increased demand for labor intensive services as the population ages. • An emphasis on community based services.	• Significant increases in demand for direct support workers that outpaces the existing labor supply. • Quality of care is compromised by loss of direct care workers through high turnover and vacancy of positions.
Recruitment Issues		
• Curricula are out of date. • Continuing education programs persist in utilizing ineffective teaching strategies. • No planning to systematically recruit staff.	• Quality of care depends on the stability of staff, so retention is crucial. • The supply of workers is not growing fast enough.	• Vacancy rates of 7 to 30 percent. • A cost of $3,200 to hire a new employee. • Low wages and a lack of benefits are important factors.
Retention Issues		
• Data and information on workforce is not complete, or based on different time frames, or not user friendly, or are not available. • No planning to systematically retain staff. • The current workforce is aging with many nearing retirement.	• Barriers include high turnover rates and erratic work schedules. • Barriers include limited advancement, low wages and few benefits.	• Turnover rates for direct care workers of 53 percent. • Turnover rates for supervisors of 25 percent. • High turnover rates add to provider costs increasing demand for replacement workers and new workers. • Direct support workers make less than the federal poverty level for a family of four. • Limited access to health insurance and other benefits for direct support workers.
Education and Training		
• Workers who are face to face with consumers get the least education/training. • Training is most often provided for like professionals only.	• Barriers include inadequate training and orientation.	• Workers who are face to face with consumers get the least education/training.
Lack of Clinical Supervision		
• Erosion in clinical supervision. • Little supervision or mentoring is provided. • Service systems thwart, rather than support, the competent performance of staff.	• Public policy provides inadequate funding for job quality, varying training standards, and little supervision and support to workers.	

Current Workforce Issues of the NC Public MH/DD/SA Services System

The reports from both the Annapolis Coalition and the North Carolina Institute of Medicine, as referenced earlier in this report, provide excellent in-depth studies of the overall healthcare workforce and provider supply. They agree that all these human service industries are going to increasingly demand a larger workforce in North Carolina. As a result, the public mental health, developmental disabilities and substance abuse services system will continue to be in competition with other healthcare agencies to hire and retain employees.

This is experienced directly at the Division's state operated facilities. In a recent examination of the workforce at those facilities over the most recent three state fiscal years, management found the following:

- The average annual turnover costs for all evaluated facilities totaled over $11 million.
- The total turnover rates for various job classifications were: nurses 21.9 percent, pharmacists 11.76 percent, psychologists 19.83 percent, physical therapists 15 percent, occupational therapists 13.19 percent, speech-language pathologists 11.54 percent, mental retardation habilitation counselors 16.50 percent, social workers 19.18 percent, substance abuse counselors 18.46 percent, health care technicians 16.55 percent, and physicians 15.28 percent.
- Staff report that with the increase in community-based services, competition with private providers for professional and direct care staff has increased. State employees must follow the N.C. Office of State Personnel rules, classification and salary levels, while private companies have more flexibility with salaries, bonuses and benefits.

In order to determine the degree to which current workforce issues affect the public mental health, developmental disabilities and substance abuse services in communities, the Professional and Direct Support Staff Subcommittee undertook a series of listening sessions or focus groups with stakeholders.

The Division partnered with the Behavioral Health Care Resources Program (BHRP) in the School of Social Work of the University of North Carolina at Chapel Hill to administer surveys and conduct focus groups across the state to determine key workforce issues facing stakeholders.[51] See appendix F for the complete report on this work.

All the issues and problems identified at the national level were found to be present in North Carolina's workforce. The respondents specifically identified the following as significant workforce problems and issues in the current public mental health, developmental disabilities and substance abuse services system. Participants also offered a number of potential solutions.[52] The results are shown in table 6.

[51] Behavioral Health Care Resources Program (BHRP) in the School of Social Work of the University of North Carolina at Chapel Hill, North Carolina MH/DD/SAS Workforce Analysis Project, August 2007.

[52] Respondents to online surveys included 65 providers and human resource managers, 37 consumers, 13 trainers and two educators. In addition, BHRP staff members conducted five focus groups of consumers in Asheville,

Table 6. Results of focus groups for workforce development

Workforce Problems/Issues	Potential Solutions
Current Staffing	
• Insufficient # of qualified professional staff • Turnover • Underpaid staff • Lack of bilingual staff • Large caseloads • Labor intensive services/supports for some consumers • Erratic work schedules	• Recruitment through job fairs, career exploration in schools (every level) internet, other states, open houses, fliers, conference exhibits, finders' fees, contingency programs, employee referral program, and hiring bonuses. • Creative marketing • Recognition & rewards program • Child care and transportation • Screening & realistic job previews • Pre-employment drug tests • Interviewing guides • Standardized hiring practices • Education & other incentives • Valuing employees • Career path • Pay rate & structure • Good benefits • Loan forgiveness program • Job sharing • Flexible schedules • Raising standards of pay and accountability • Retention: educational & other incentives, valuing employees, competency based certification process, job sharing, career counseling, professional association • Better job descriptions
Supervision Issues	

Chapel Hill, Charlotte, Greenville and Wilmington and five focus groups of providers and human resource managers in Asheville, Chapel Hill, Charlotte, Fayetteville and Wilmington. See the report for details of these efforts.

Workforce Problems/Issues	Potential Solutions
• Inadequate number of licensed staff & need for supervision to obtain license • Licensing requirements & supervision	• Use of mentors • Practical experience (internships, rotations, work study, shadowing, field placements)
Need for Training	
• Unqualified staff, inadequately trained & inexperienced • Consumers need education • Fear a professional will leave after receiving training or license	• Ongoing on-the-job training • 20-hour curriculum for community support at community colleges • List of community resources • List of providers • Guidance in selecting a provider • Online training • Competency based certification process • Communication between management and direct care staff • Training and certification for paraprofessionals • Human services curricula • Collaboration with community colleges, technical colleges, colleges & universities • Database of training and attendees • Online training • Credit at community colleges for specific training • Internships as post-graduate credit • Registry of providers (professionals?) with certification • Adequate supervision at every level • Statewide certification process
Management Issues	
• Disconnect between service definitions, licensure and certification • Fear of paybacks • Confusion about billing of provisionally licensed staff • Increased paperwork • Fear of IPRS funds running out • Service gaps in rural areas • Inadequate rate structure	• Handbooks for managers • Funding • Tighter monitoring of providers by local management entity (LME) staff

Workforce Problems/Issues	Potential Solutions
• Lack of clarity about audit requirements • Focus on provider financial stability over service provision • Inflexible funding • Lack of leadership at provider agencies	

The North Carolina Council on Developmental Disabilities contracted with the Research and Training Center on Community Living, University of Minnesota to hold listening sessions in May and June 2007 with direct support workers, individuals with disabilities who received services and their families. The listening sessions addressed the challenges they face and ideas about solutions. These individuals receiving services from direct support workers include those with developmental disabilities, mental illnesses, and the elderly.

A total of six sessions were conducted with 44 participants. The results of these listening sessions are summarized in table 7 and have been used to inform the recommendations provided in this report. For a complete description, see the companion report by Amy Hewitt, et al., *Direct Support Professional Work Group Report*, October 2007.

Table 7. Results of listening sessions for Direct Support Workforce Development

RECRUITMENT	
Question: ***What are the best ways/ places to recruit direct support staff?***	
Mental Health/Substance Abuse	**Developmental Disabilities**

• Very difficult to recruit due to specificity of service definition and required roles
• Collaboration among providers to raise awareness of available jobs (job fairs), rather than the more traditional, competitive approach
• Recruit through NAMI, Mental Health Association
• Little response to newspaper advertisement
• LME matching provider contributions to recruitment efforts have been effective
• Rural areas difficult to recruit to (particularly for positions requiring extensive experience/credentials), have demonstrated some success in using natural beauty of area as recruitment tool.
• Schools of Social Work and SA credentialing programs have been fertile recruiting grounds
  o Get on university resource lists
  o Participate in school job fairs
  o Build personal relationships with school faculty/administrators as means of recruitment
  o Offering internships that can turn into full time employment after graduation
• Offering credentialing programs has proven effective in recruiting
• Higher pay
• Offer opportunities for staff to earn their provisional licensure while getting paid
	• Find staff through colleges/universities – market through PT, OT, nursing, Psychology, Social Work programs
	• Accessing list-serves
	• Word of mouth
	• Engagement of Employee Security Commission in recruiting efforts (holding job fairs on site at the ESC)
	• Conduct job fairs/expos within health care settings
	• Develop relationships with professionals in health care settings
	• Staff referrals (with bonus to referring staff) are effective as a recruiting tool
	• Approaching guidance counselor offices within high schools
	• Use current direct support workers as recruiters (all staff carry applications/brochures with them)
	• Consumer participation in recruiting/interviewing process
	• Public awareness campaigns (billboards, PSAs, TV, etc.) to bring exposure to the field, also reduces anxieties many people have about disabilities
	• Engage the business community in recruitment efforts
	• Recruit people participating in TANF (Welfare to Work programs)
	• Work with Better Business Bureaus to market organizations
	• Flyers in community gathering areas
	• Children with disabilities in inclusive school models would increase awareness and help recruitment to the field
	• Avoid acronyms and use general language to describe jobs (no jargon)

RETENTION

Question: ***Why do direct support workers leave their jobs?***

Mental Health/Substance Abuse

- Decisions surrounding licensure often made around what is best within urban areas (i.e. Raleigh) rather than more rural areas
- Constantly changing regulations/paperwork requirements
- People swamped with paperwork rather than actually providing services
- No investment in the area of service (people working in native communities more likely to stay)

Developmental Disabilities

- Low ceiling, no room to advance
- Poor supervision
- No recognition
- Pay not commensurate with difficulty of job
- Too large a caseload
- Little opportunity for continuing education
- Lack of benefits
- Little job security (constantly in fear of losing their job)
- No clear job descriptions
- Stress/burnout
- Family obligations do not match with demands of the job
- Cost of gas (given scattered nature of service sites)

Question*: How can agencies reduce staff turnover?*

Mental Health/Substance Abuse

- Reduce the amount of paperwork through more efficient use of documentation (less repetition of information)
- Less frequent change of requirements/regulations (people get trained to do something, then it changes)
- More effective systems change (rather than quick fix mentality)
- Create regulations appropriate to population served rather than blanket regulations (i.e. PCP process not appropriate for someone who needs immediate service such as SA consumer)
- Offer more comprehensive benefits (i.e. health insurance, etc.)
- Up front guidelines about expectations, clear job expectations to reduce surprises
- Job shadowing programs
- Greater utilization of technology to reduce paperwork and keep up with employees in community settings
- Improved supervision practices (more investment in supervision training)

Developmental Disabilities

- Higher pay
- Provide better benefits to employees (health insurance, reliable vacation planning, etc.)
- Greater career paths/benchmarks for success and experience
- Improved training
- Realistic job descriptions/expectations
- More training about disability specific issues to increase staff understanding
- Standardized training/credentialing program
- More full time job opportunities
- Better supervisors (more supervisor training regarding role modeling and effective leadership), supervisors with more "real-life" experience
- Better screening processes for incoming staff
- Greater usage of family members as direct support workers
- More investment in "take care of the caregiver"
- Peer to peer support programs, access to support resources
- Greater reimbursement for expenses (mileage, meals, etc.)

TRAINING AND SUPPORT

Question: ***What skills are needed by the workforce?***

Mental Health/Substance Abuse

- Familiarity with Medicaid rules/structures
- Strong communication (verbal and written) and observation skills
- Logical, analytical, decision-making skills
- Background in content area (via academic/school-based training)

Developmental Disabilities

- Must understand the "Golden Rule" (Do unto others as you would have them do unto you)
- Understanding of the weight/responsibility of caring for another human
- Understanding of Person Centered Planning/Thinking, willingness to get to know consumers on an individual level
- Good communication skills (verbal & written)
- Strong decision-making and problem-solving skills
- Awareness of community activities/opportunities for greater participation and integration
- Ability to recognize consumer talents/creativity
- Basic computer skills
- Basic math/reading/writing skills

Question*: What kind of training does direct support staff need?*

Mental Health/Substance Abuse

- Communication training
- On-the-job training/job shadowing
- Crisis recognition and response training

Developmental Disabilities

- Healthcare/medication administration/CPR
- Basic overview of disability issues/diagnostic information
- Individualized training (people are different, no template for services)
- Training that is engaging and held frequently (quarterly?)
- Understanding of emergency resources
- Portable training that can be taken from job to job (more standardized)
- Greater inclusion of disability material in school/college curricula
- Total immersion and cross training across work sites to help staff become more well rounded
- Put people in the role of receiving services to experience consumer perspective
- Leadership and management training for direct support workers who hope to someday get promoted

Question: ***What kind of things can employers do to better support direct support workers in their jobs?***

Mental Health/Substance Abuse

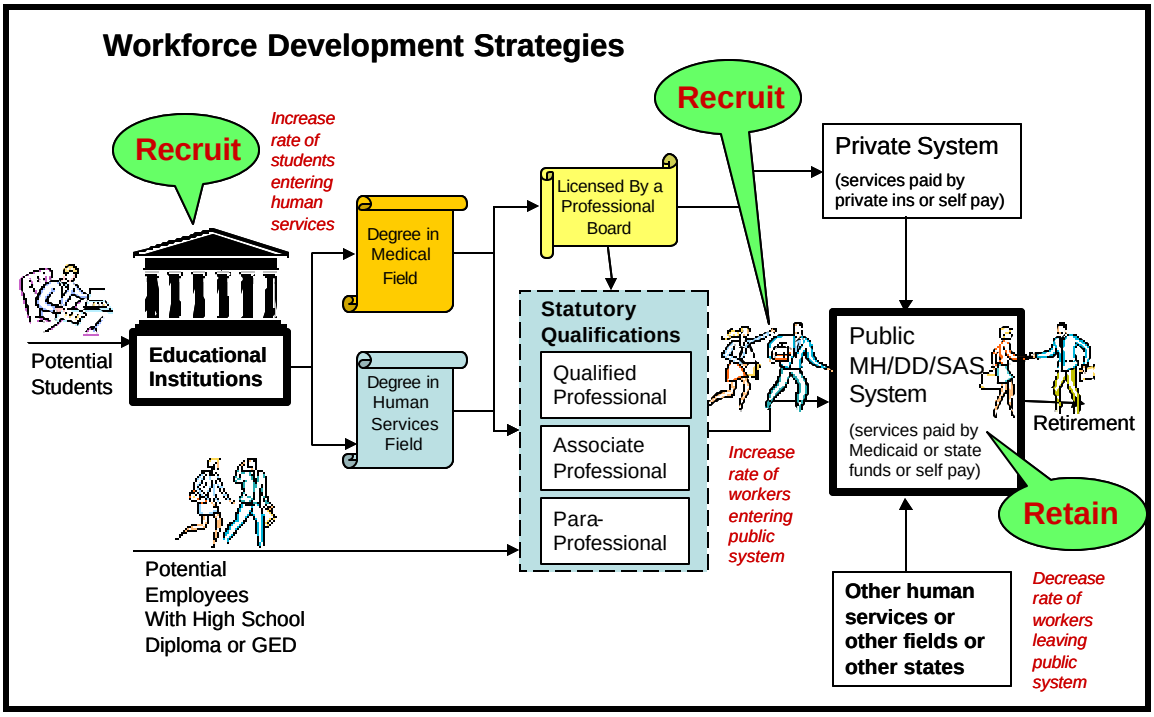
- Encourage participation in trainings/conferences external to agency (increases recognition and investment).
- Opportunity to be listened to regarding organizational direction and activities.
- Offer a living wage (without having to work 60 hr/wk).
- Safe/secure organizational culture (people scared for their jobs will not be effective workers).
- Rewards/incentives for good work done.

Developmental Disabilities

- Greater recognition for work performance.
- Reduce paperwork requirements to allow people to concentrate on actual service provision.
- Value input from direct support workers, create team approach to services.
- Provide positive feedback.
- Rewards/incentives for good work (specific acts, not just "good job").
- Focus put on staff rights/needs as well as consumers' rights/needs.
- Accessibility of supervisors and administrators for direct support workers concerns and suggestions.
- Opportunities for new challenges.
- Less bureaucratic approach to dealing with direct support workers (more personal relationships).
- Offer higher-level trainings to direct support workers (rather than only supervisors, admin.).
- Education of human resource/personnel departments surrounding issues pertinent to direct support workers.

Strategies for Workforce Development

Workforce development is dependent on two basic sets of strategies. The first is to recruit new workers and the second is to retain current workers. Both are important. The former ensures the future workforce and the latter focuses on the quality and stability of the current workforce. Following are examples of strategies for recruitment and retention taken into consideration by the Commission and the Division in formulating their recommendations.



Recruitment Strategies

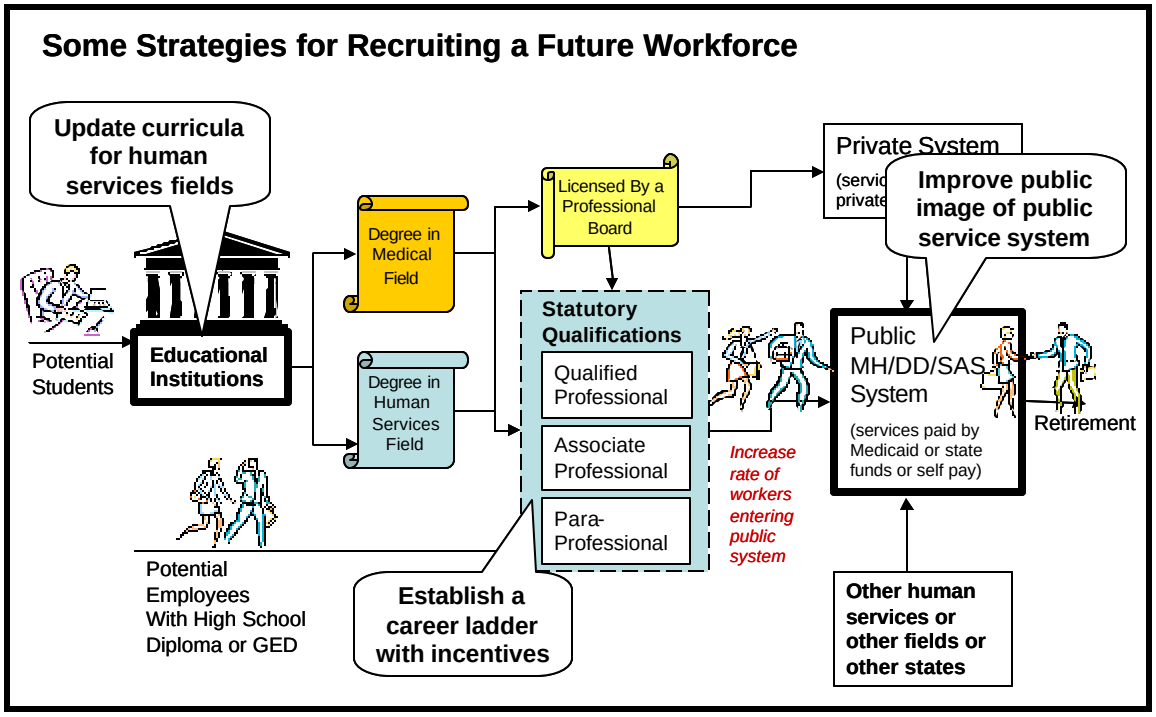
Strategies to recruit employees that will constitute a stable, ongoing workforce in the future for the public mental health, developmental disabilities and substance abuse services system may be categorized in the following way.

Strategies to meet immediate needs:

- Reward staff who recruits someone who stays on the job.
- Use structured behavior interviews.
- Use realistic job previews.
- Demonstrate competencies for the job.
- Increase personnel advertising budgets.
- Advertise in well known trade journals and internet sites.

Strategies to meet long-term needs:

- Establish core competencies.
- Develop career ladders.
- Establish an apprenticeship program.
- Establish new core curricula for healthcare in educational institutions.
- Improve public image of the system.
- Recruit workers from neighboring states.
- Provide financial and other support for increased education.
- Establish residency and fellowship programs at state facilities to develop in-house expertise of clinicians who might later commit to communities.



Retention Strategies

Quite a number of strategies to retrain current staff have been suggested by the national studies, the survey of state operated facilities, and the surveys and focus groups conducted in North Carolina for this project. There are a variety of approaches and actions that might be taken and might be categorized as follows.

Supervision
- Increase the number of supervisors.
- Enhance the skills of supervisors.
- Improve organizational management practices.

Competencies and Training
- Define the competencies of staff working in communities.
- Increase on-the-job and ongoing training.
- Use on-line training.
- Develop database of individuals and training completed.
- Provide financial and other support for increased education.

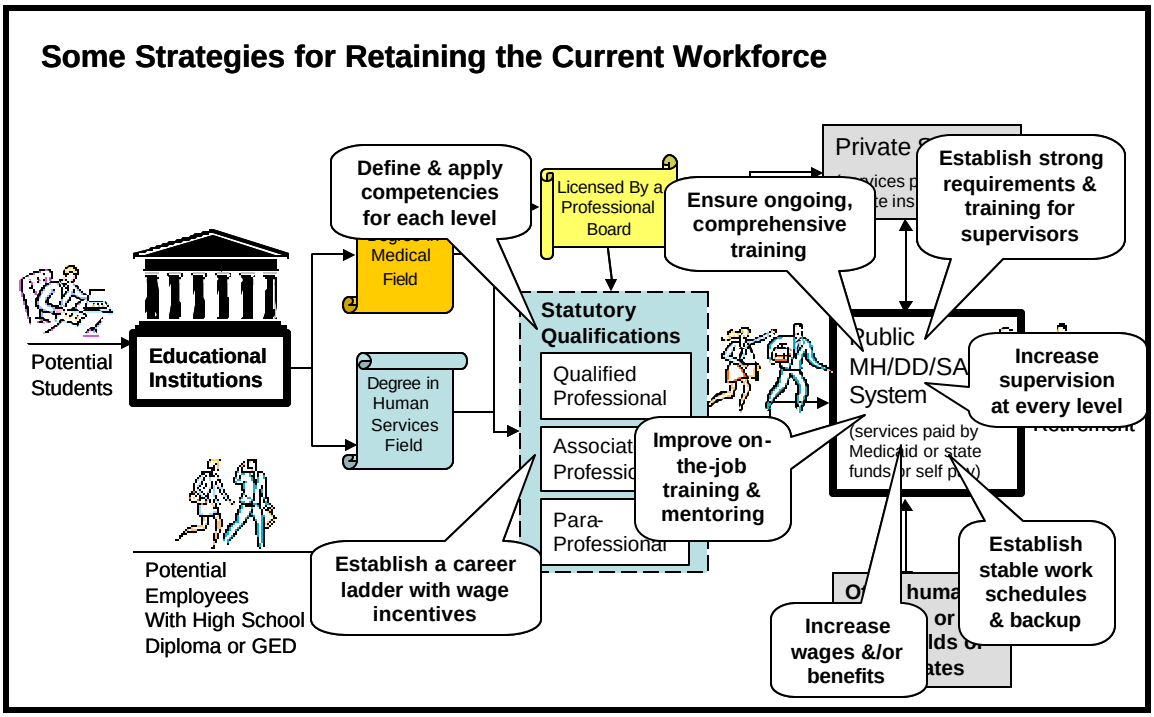
Advancement
- Develop career ladders for advancement.
- Develop and implement a succession plan.

Recognition
- Develop worker organizations and journals.
- Provide incentive awards.
- Develop registries of workers.
- Participate in decision-making.

Wages and Benefits
- Improve wages and/or health benefits.
- Examine the limitations of the state personnel system.
- Establish stable work schedules & backup.

Other Strategies

- Increased use of technology to enhance the delivery of services, e.g. virtual counseling and telepsychiatry.
- Increased emphasis on preventive care.
- Pay for preventive care.
- Reimbursement analysis.
- Labor market analysis.
- New contracting standards.
- Work with local chambers of commerce to tie economic development with technical assistance to providers as businesses.
- Collaboration with workforce initiatives sponsored by the North Carolina Department of Health and Human Services and its other divisions and the Department of Labor or Employment Security Commission.
- An educational assistance subsidy funded by the N.C. General Assembly for community college courses that lead to a degree in human services.



Evidenced Based Strategies for the Direct Support Workforce

A number of researched based interventions have been identified as effective at improving direct support worker retention and competence. These strategies involve finding and hiring employees, socializing and training employees, motivating and supporting employees. Demonstrations involving one or more of these interventions have been effective at reducing direct support turnover in a number of organizations in various states in both human services and long-term care aging services. Brief descriptions of these interventions are identified here.

Recruitment - Recruitment is part of the organizational entry process. It involves letting people know about open positions and available jobs. Studies have indicated that the most common ways in which organizations in human services advertise for open positions is advertising in the newspaper and using existing employees to find new employees[53]. Unlike other industries, the community human services and long-term care industries rarely rely on radio and television ads, referral agencies or job fairs. In a review of best practices conducted by the Centers for Medicare and Medicaid Services, a number of successful marketing strategies were identified. These included web-based registries that match people with open positions to people looking for direct support jobs, and the use of community sponsored events such as job fairs.[54]

[53] Test, D. et al., North Carolina direct support professionals study: Final report. Charlotte: University of North Carolina at Charlotte, 1999; NYSARC, 2000.
[54] The federal Centers for Medicare and Medicaid, 2007, see: http://www.cms.hhs.gov/HCBS/downloads/qc3_020904.pdf

Using inside recruitment sources is another effective strategy for increasing the probability that workers who are hired will actually stay in their jobs. Inside sources provide information not typically known by persons outside the company. Examples of inside sources are rehires, referrals, in-house job postings that are targeted at current employees, volunteers, and friends of staff members. The research support for using inside recruitment sources shows that the number of months a new hire stays in the organization is about 24% higher when inside sources are used.[55]

Realistic job previewing - Realistic job previews give potential new hires an accurate and clear picture of the job for which they are interviewing. This preview is given to them *before* a job offer is made. Using realistic job previews gives applicants an opportunity to make an informed decision about whether they really are a good match for the job and if they want to accept a job offer if made. A realistic job preview includes both positive and negative information about the various aspects of the job conveyed by the people who do the work, in this case, direct support workers.

Ensuring that applicants have a good understanding of the job for which they are applying can support better retention. Research shows that when new employees have unmet expectations about the job, this can result in lower job satisfaction, which can cause newcomers to leave their positions. In a study conducted at the University of Minnesota, new hires in community residential direct support jobs that had fewer unmet expectations were significantly less likely to quit in the first 12 months after hire than those who had greater unmet expectations.[56] Realistic job previews can reduce the likelihood that newly hired employees will leave their positions because of unmet expectations about their jobs.

Orientation, socialization, networking and professionalization – When new workers are hired, they often come to their new job with little to no experience. They need a variety of supports to be successful in their new job. They need assistance in understanding the informal aspects of the job - "how things are done" - and information and training on how to do the specific tasks and duties of the job. New employees report that one of the greatest challenges in starting their new job is getting to know the people they provide supports to (e.g., characteristics, routines, likes, dislikes), learning their job duties and getting to know their co-workers. These challenges make it a stressful start for most new direct support workers.[57]

One effective strategy to address this socialization challenge is enabling direct support workers to learn from one another. In 1994, a study of newly hired direct support workers found that when they were supported by their coworkers they were more likely to stay than those who did not have this support.[58] In this study, there were several components of co-worker support that were deemed important, including: 1) existing direct support workers are personally supportive of the new staff person, 2) existing staff with experience see one aspect of their job as training

[55] Wanous, J.P., Organizational entry: Recruitment, selection, orientation and socialization of newcomers (2nd ed.). New York,: Addison Wesley, 1992.
[56] Larson, S.A. et al., Staff recruitment and retention: Study results and intervention strategies. Washington, DC: American Association on Mental Retardation, 1998.
[57] Ibid.
[58] Bachelder, L. & Braddock, D. Socialization practices and staff turnover in community homes for people with developmental disabilities. Chicago: University of Illinois at Chicago. 1994.

newcomers, 3) existing staff give newcomers advice and guidance on how to do their job, and 4) the training provided by the organization builds on experience of the new staff person. Another study found that coworkers are the most available source of socialization information.[59]

Supervisors also play an important role in orientating and socializing new employees. Research suggests that the information provided by supervisors about the tasks and roles of new employees is an important factor in socialization satisfaction, commitment, and feelings of adjustment.[60]

Competency-based training – Competency-based training is training that focuses not on rules and regulations, but instead on the knowledge, skills and attitudes required of new employees to be effective at direct support. Competency-based training programs are focused on work performance and results. They are based on specific, precisely stated outcomes, usually called competencies or tasks, that are viewed as essential for successful employment in the given occupation. These competencies describe exactly what the learner should be able to do upon completion of the training program. Competency-based training programs give learners time to master one task, before moving on to the next. Learners are required to perform each task in the work environment before receiving credit for attaining each task. These training programs typically avoid dictating the method of instruction, thus allowing for more flexibility within organizations and educational institutions.[61]

For some groups of direct support workers, national job analyses have been conducted in order to identify the necessary competencies required of people who work in direct support. Competency-based training programs are effective at teaching people the skills they need to do their jobs. Competency-based programs are more effective than dictating the number of hours of required training or focusing training on specific rules and service definitions. In North Carolina, all training required of direct support workers is currently hours-based and not competency-based.

Mentoring - Four out of five CEOs of Fortune 500 companies attributed a significant proportion of their success to having had a mentor.[62] Mentoring programs were one of many interventions used in community living services that successfully resulted in turnover reductions by as much as 18%.[63] Table 8 provides an overview of benefits of effective mentoring programs.[64]

Table 8: Benefits of a Mentorship Program

Key People	**Benefits to those Key People**
Organization	• Low cost method to communicate vision/mission/best practice • Better quality supports • Fosters development of employees • Strengthens retention and reduces turnover

[59] Louis, M.R. et al., The availability and helpfulness of socialization practices. Personnel Psychology, 36:857-866, 1983.
[60] Ibid.; Ostroff, C. & Kozlowski, S.W.J. Organizational socialization as a learning process: The role of information acquisition. Personnel Psychology, 45: 849-874, 1992.
[61] Fiorelli et al., 1982.
[62] Bell, 2002.
[63] McCulloh, Larson, Hewitt, 2007.
[64] Taylor, Sauer, Hewitt, O'Nell, & Larson, 2001.

Table 8: Benefits of a Mentorship Program

Key People	Benefits to those Key People
New Hires	• Stronger employee commitment • Tap into accumulated knowledge and experience of mentor • Safe opportunity for feedback • Place to bring anxiety and concerns • Connect socially with others • Decrease feelings of isolation • Gain access to information • Guidance on norms
Mentors	• Recognition for skills and abilities • Opportunities to develop new skills and advancement • Renewed interest in job • Raises, bonuses, and rewards
Consumers	• Better services • Less turnover • Positive long-term relationships

Supporting and training supervisors to support a diverse workforce - Supervisors are critical to effective hiring, training, and retention of direct support workers.[65] Organizations that have new or ineffective supervisors have higher direct support worker turnover rates.[66] Direct support workers often leave their positions for reasons in which the supervisor pays a critical role: 1) difficulties in getting along with co-workers, and 2) conflicts with supervisors.

Many supervisors may have been promoted to their position because they were good at performing direct care. However, they are often thrown in to their supervisory position with little training and support. Instead, they learn through trial and error. Supervisors reported that they liked having opportunities for networking, practicing the information they learned, and attending training provided outside the organization.[67] In a recent national report on the behavioral health workforce[68], increased attention to supervision was cited as a key strategy in improving the quality of the workforce. Previous demonstration and evaluation projects conducted by the National Institute on Disability and Rehabilitation Research (NIDRR) funded Research and Training Center on Community Living and the Centers for Medicare and Medicaid have shown that when organizations implement training supervisors as one of several evidence based workforce interventions, they can reduce their turnover rates by 4 percent to 15 percent on average.

There are a number of identified competencies required of effective supervisors in community based human services. These competencies include the following topical areas: (a) enhancing staff relations; (b) providing and modeling direct support; (c) facilitating and supporting

[65] Cohen, 2000; Hewitt, A. et al., An independent evaluation of the quality of services and system performance of Minnesota's Home and Community Based Services for persons with mental retardation and related conditions. Minneapolis: University of Minnesota, Research and Training Center on Community Living, 2000; Lakin, Bruininks, Hill, & Hauber, 1982; Larson, Lakin, & Hewitt, 2002).
[66] Larson, Lakin, & Bruininks, 1998.
[67] Larson, Sauer, et al., 1998.
[68] Hoge, M.A., et al., An Action Plan for Behavioral Health Workforce Development, The Annapolis Coalition on the Behavioral health Workforce, Cincinnati, 2007.

consumer support networks; (d) planning and monitoring programs; (e) managing personnel; (f) leading training and staff development activities; (g) promoting public relations; (h) maintaining homes, vehicles, and property; (i) protecting health and safety; (j) managing finances; (k) maintaining staff schedules and payroll; (l) coordinating vocational supports; (m) coordinating policies, procedures, and rule compliance; and (n) performing general office work.[69]

Regulatory Issues and Actions

The Ad-hoc Subcommittee on Regulatory Matters was charged with examining statutes, rules/regulations, and policy which impact workforce development. Discussions focused upon the following issues: availability and retention of workers, examination of competency-related and accountability issues, defining work-related experience, consideration of training issues, and reviewing costs associated with each of these factors. The Subcommittee focused the majority of its discussion upon addressing workforce issues related to Direct Service Workers.

Licensure requirements and other staff qualifications related to the provision of mental health, developmental disabilities and substance abuse services are contained within the Enhanced Service Definitions,[70] the services available through the Community Alternatives Programs for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD)[71], and the North Carolina General Statutes and the North Carolina Administrative Code.[72] The new service definitions are based more on education than on work experience.

In addition to examining the content of existing rules, their impact includes the ability to compensate workers by giving some consideration to their skill set as well as to how billing requirements limit/impact agency ability to compensate workers. Accountability remains an issue in terms of addressing workers who do not have related job experience or fail to meet education requirements for the provision of mental health, developmental disabilities and substance abuse services. Measures should be put in place to test a worker's baseline competency.

Several questions raised by members to be addressed as part of the Ad-hoc Subcommittee on Regulatory Matters' mission include:

- Is it the provider's responsibility to pay for training qualified professionals and paraprofessionals? If not, where does the responsibility reside? Is the responsibility for payment specified in rule/licensure requirements?
- Is there a competency-based training system for licensed professionals?

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[69] Larson, S.A., et al, National Validation Study of Competencies for front line supervisors and direct support professionals: Final Report. Minneapolis: University of Minnesota, Research & Training Center on Community Integration, 2007.

[70] See North Carolina's Division of Medical Assistance Medicaid Policy 8A on that division's web page at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

[71] See the Division's web page at http://www.ncdhhs.gov/mhddsas/cap-mrdd/index.htm.

[72] See: 10ANCAC 27G .0104 for staff definitions in the North Carolina Administrative Code. See appendix E for a copy of this code.

    - If so, how is competency defined?
    - Is a formal testing application used?
    - Will education/training/continuing education be viewed as evidence of competency?
- Is there a competency-based training for qualified professionals and paraprofessionals?
    - If so, how is competency defined?
    - Is a formal testing application used?
- Is continuing education required?
    - Is continuing education available?
    - What are the barriers surrounding making it accessible for all – cost, transportation, time commitment, internet access, etc?
- How do you train a part-time workforce?

Conclusions

Having researched workforce information through subcommittees, heard presentations from national consultants, and studied the results of various other workforce development efforts, the Commission and Division have taken into consideration various strategies and approaches to the workforce issues for the public mental health, developmental disabilities and substance abuse services system. The Commission and Division have agreed to the following steps:

1. To support the formation of a work group led by the Division's Chief of Clinical Policy to review staff qualifications as currently set in rule for qualified professionals, associate professionals and paraprofessionals and to make recommendations for changes to such rules as appropriate.
2. To identify and strengthen partnerships with other stakeholders - including educational, governmental, consumers and families, advocacy organizations, and professional organizations - to build the needed workforce over time. (See the next chapter for discussion of this endeavor.)
3. To recommend specific workforce development short-term and long-terms strategies for implementation by the Division and its partners. (See the final chapter of this document for those recommendations.)

Workforce Development through Strategic Partnerships

For workforce planning to be successful, partnership with the various organizations and stakeholders in the outcome is essential. Within any organization, the stakeholders include human resources, planning, senior managers, and staff that are supported by a budget. Communication has to move in a multidirectional way, bottom-up, top-down and across organizations. All customers are considered important partners in this communication effort.

Initiation, organization and mobilization of strategic partnerships for the public mental health, developmental disabilities and substance abuse services system involve identification of those organizations that have an interest in developing the workforce. It is then possible to begin to understand the responsibilities and needs of all involved and the actions to address those needs.

Secondly, workforce analysis includes the consideration of demographic information: occupations, grade levels, skills and experience, age, retirement eligibility, diversity, turnover rates, etc. In addition, it is necessary to conduct competency-based assessments and compare workforce needs against available skills. Do workloads match resources and staffing requirements?

Human resource specialists can provide management with the tools for developing new competencies in the workforce, training employees, recruiting staff with core competencies, performing workforce analysis and developing succession-planning models when needed. Making this partnership work requires that human resource offices develop the full range of human resources competencies among their staff, including workforce analysis.[73]

Table 9 identifies organizations and groups that have a stake in workforce development for the public mental health, developmental disabilities and substance abuse services system. It attempts to answer the following questions concerning the development of the workforce:

- Who are the partners and stakeholders?
- What are the responsibilities of each?
- What are the perceived needs of each?

[73] The Federal Workforce Planning Model, see: http://www.opm.gov/workforceplanning/wfpmodel_step1.htm.

Table 9. Stakeholders in the public MH/DD/SAS system

Stakeholders	Responsibilities	Needs
General Assembly and the Legislative Oversight Committee	Statutes. Funding.	Meet needs of the residents of the State of N.C.
The Department of Health and Human Services	Set policies and standards. Sponsor major job fairs.	Successful outcomes for consumers and families.
The Division and its state facilities	Set policies and standards. Monitor system performance. Achieve desired consumer outcomes.	Highly qualified and stable local management entities (LMEs) and providers that perform at or above desired system levels and produce desired consumer outcomes.
Local Management Entities (LMEs)	Perform contracted local management entity (LME) functions, including: • Provider endorsement. • Monitor provider performance.	Qualified staff to perform contracted local management entity (LME) functions. Highly qualified and stable providers that produce desired consumer outcomes.
Providers	Provide endorsed services that produce desired outcomes for individual consumers.	Qualified professionals, associate professionals, paraprofessionals, business acumen.
Consumers & Families	Seek and participate in appropriate services. Speak up for their rights.	Quality services and supports to meet their individual needs.
Educational Institutions • Community Colleges • Technical Colleges • Universities • Area Health Education Centers (AHECs) • Private trainers • Behavioral Health Research Institute • Developmental Disabilities Training Institute	Educate students in fields of study that lead to qualified job performance or the maintenance of those qualifications.	Currently relevant curricula and professors. Interested students.
Advocacy Organizations	Advocate for consumers in receipt of services that are best practices. Inform consumers about services and rights.	Successful outcomes for consumers and families.
Professional Organizations	License professionals according to NC statutes.	Professional members that meet standards and requirements.

Stakeholders	Responsibilities	Needs
	Provide support and information for members.	
Division of Medical Assistance	Obtain Medicaid approval for services and rates	Information about actual utilization of Medicaid funds.

Other agencies and organizations that might contribute as partners to workforce development include:

- The Department of Health and Human Services
- State and local consumer and family advisory committees
- Local governments and county commissioners
- Job Link centers
- Foundations
- Faith-based organizations
- Department of Correction
- Department of Public Instruction
- Department of Juvenile Justice and Delinquency Prevention
- Employment Security Commission
- Department of Labor

Recommendations

This section presents the recommendations of the Workforce Development Initiative undertaken by the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

With a goal of ensuring the highest quality and adequate quantity of services for consumers, the Commission and the Division considered multiple potential recommendations in review of the complex issue of workforce development. The Commission and the Division reviewed ideas that ranged from broad values to specific tasks submitted by its subcommittees, stakeholders and consultants and the reports of national organizations.

In summary, the Commission and the Division found that the workforce issue is highly complicated by (1) the growing population in North Carolina, and thus an increasing demand for all of healthcare, and (2) studies that indicate the healthcare workforce will not keep up with that demand given current trends.

Competition is and will continue to be strong at all levels – for psychiatric and medical care, for staff in our community hospitals and psychiatric hospitals, for staff in alcohol and drug treatment centers, for staff in developmental centers and neuro-medical centers, and for staff who provide direct care for consumers, for licensed mental health professionals, for licensed substance abuse professionals and for other healthcare workers in communities.

In addition, the North Carolina public system of mental health, developmental disabilities and substance abuse services currently experiences an inadequate number of staff statewide. Many are inadequately trained and supervised and turnover rates are high. Retention of current staff and recruitment of future staff need prompt and intensive attention.

Given that thoughtful attention has been given to behavioral healthcare and direct support workforce issues at the national level, the Commission and the Division elected to use the report of the Annapolis Coalition as a framework for its recommendations.[74] The high level categories of the Annapolis Coalition report are:

- Broadening the concept of workforce.
- Strengthening the workforce.
- Structure to support the workforce.

As summarized in table 10, the 12 specific recommendations for North Carolina are organized as bulleted items using these categories. Each specific recommendation is discussed in greater detail in this section of the report.

[74] The Annapolis Coalition on the Behavioral Health Workforce, An Action Plan for Behavior Health Workforce Development, A Framework for Discussion, Executive Summary, 2007, See: http://www.annapoliscoalition.org/

Table 10. Recommendations for mental health, developmental disabilities and substance abuse services workforce development in North Carolina

STRUCTURES TO SUPPORT THE WORKFORCE
***Recommendation 1**: Develop a detailed plan of action for implementation of these recommendations under the oversight and involvement of the Commission and the Division.*
***Recommendation 2**: Create a consistent means to identify data and other information about the status of the North Carolina public mental health, developmental disabilities and substance abuse services workforce as a quality improvement function and report annually to policy makers.*
***Recommendation 3**: Employ within the Division a Workforce Development Specialist who has expertise in the assessment of workforce issues and development of solutions and who will serve as the project manager for carrying out the plan of action for implementing the recommendations identified in this report and other workforce initiatives of the Division.*
BROADENING THE CONCEPT OF WORKFORCE
***Recommendation 4**: Create new service options for consumer directed services for all individuals with disabilities and, as appropriate, for their families.*
***Recommendation 5**: Create a workforce marketing and public awareness campaign for all types of staff positions in the public mental health, developmental disabilities and substance abuse services system.*
STRENGTHENING THE WORKFORCE
***Recommendation 6**: Optimize wages and benefits for professional and direct support workers serving consumers of the public mental health, developmental disabilities and substance abuse service system.*
***Recommendation 7**: Create selection tools to assist providers in reducing early turnover of workers.*
***Recommendation 8**: Improve access to psychiatric, other medical and non-medical care for individuals served by the public mental health, developmental disabilities and substance abuse service system.*
***Recommendation 9**: Create coordinated curricula and certification plans for professional and direct support workers.*
***Recommendation 10**: Provide systematic training, technical assistance and incentives to all providers statewide on effective recruitment, retention and training practices.*
***Recommendation 11**: Foster, encourage and support system wide training to frontline supervisors and managers on effective supervision.*
***Recommendation 12**: In order to create positive work environments, provide opportunities to empower professional and direct support workers serving consumers of publicly funded mental health, developmental disabilities and substance abuse services.*

Structures to Support the Workforce

Recommendation 1: Develop a detailed plan of action for implementation of these recommendations under the oversight and involvement of the Commission and the Division.

The undertaking of this large and complex endeavor requires first of all the development of a plan of action that identifies the specific tasks, resources, sequencing and time frames for accomplishment. This is likely to be at least five-year plan with retention being the focus for the immediate future while building the foundation for recruitment. Specific goals and objectives are identified through the following recommendations.

Recommendation 2: Create a consistent means to identify data and other information about the status of the North Carolina public mental health, developmental disabilities and substance abuse services workforce as a quality improvement function and report annually to policy makers.

The Division of MH/DD/SAS would have responsibility for gathering data and information and analyzing trends to inform policy makers, advocates and service recipients about the status of the North Carolina mental health, developmental disabilities and substance abuse services workforce. Data elements of focus should include, but are not limited to:

- The types and number of professional and direct support workers employed in mental health, substance abuse and developmental disabilities services as well as those in long term care aging services.
- Annual turnover rates of professional and direct support workers.
- Annual vacancy rates of professional and direct support workers.
- Entry, median and the range for professional and direct support worker wages.
- Eligibility and election of offered health care benefits.
- Education program enrollees and completion.
- Post-secondary education data from National Center for Educational Statistics.
- Gaps in form education among current staff of the mental health, developmental disabilities and substance abuse services system.
- Utilization of benefits.

Recommendation 3: Employ within the Division a Workforce Development Specialist who has expertise in the assessment of workforce issues and development of solutions and who will serve as the project manager for carrying out the plan of action for implementing the recommendations identified in this report and other workforce initiatives of the Division.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) should seek support for creating and employing a Workforce Development Specialist in the Division to provide ongoing leadership for statewide workforce development efforts. This person should be a qualified and experienced leader in human service workforce development.

In addition to continuing the research begun through this workforce development initiative, this person would have responsibility for workforce marketing and public awareness as outlined in Recommendation 4, strengthening the workforce as outlined in recommendations 6, 8, 9 and 10, and data collection and trend analysis as outlined in Recommendation 2. This person would need the assistance and cooperation of staff with the Division and from other state agencies to develop a model workforce action plan for individual provider agencies to adapt to their needs, including possible structure, local workforce analysis, identification of agency needs, recruitment and retention strategies, training and human resources programs.

In addition, a key role of the person would be to collaborate with the Department of Health and Human Services in its workforce initiative for all human services, including the creation and support for a Statewide Workforce Development Group. This statewide interdisciplinary group would have the responsibility for implementation and outcomes of strategies to address the professional and direct support workforce challenges, including the review of data and trends. Membership on this group should include representatives from many areas of state government and should be comprised of people in decision-making roles. This initiative should be led by the Department of Health and Human Services, in full collaboration and partnership with North Carolina Departments of Labor, Employment Security, Public Instruction, and Post Secondary Education. In addition to state level policy makers, the Advisory Group should include representatives of chambers of commerce, regional workforce development boards and other members of the community that represent the many key stakeholder groups.

Broadening the Concept of Workforce

Recommendation 4: Create new service options for consumer directed services for all individuals with disabilities and, as appropriate, for their families.

Self-direction provides the opportunity for individuals and families to find, choose, guide and manage their own direct support workers without reliance on provider organizations. This recommendation encourages the Department of Health and Human Services through its Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse to create a self-direction option for service delivery, that:

- Ensures that all individuals and families who choose a self-directed service option are trained on how to find, choose and keep their direct support workers; and
- Assists individuals and families that choose self-direction on finding and being matched with potential direct support workers through the use of a registry program for direct support workers.

In addition to supporting self-direction, the Division is committed to developing a peer workforce that would be required to demonstrate competency in recovery, rehabilitation and self-direction. This might involve the development of a legal definition of a peer support worker, specification of competencies, as well as training and means of support. While many states across the country are developing a peer workforce, there is currently no model that would qualify as best practice. North Carolina will work in conjunction with other states and national organizations as such standards are developed.

Recommendation 5: Create a mental health, developmental disabilities and substance abuse services workforce marketing and public awareness campaign for all types of staff positions serving consumers of mental health, developmental disabilities and substance abuse services.

A statewide workforce marketing and public awareness campaign in North Carolina should be developed that involves a collaboration of educational partners, providers and other state and local agencies. This recommendation calls for a well-designed and comprehensive marketing and public relations campaign that results in:

- North Carolinians' knowing who professional and direct support workers are and what contributions they make to their communities.
- A consistent occupational title for direct support workers, minimally within each service industry – mental health, substance abuse, developmental disabilities and aging.
- Marketing materials and resources that can be used to recruit specific targeted groups into professional and direct support work, including but not limited to: retirees, students, and displaced workers (e.g. web-site, video, flyers). These materials should be used within the workforce development center, K-12 education and other community resources where people are looking for careers.
- Recruitment of a workforce through job fairs and conferences.
- Recruitment of a workforce through career explorations in schools at every level.

Strengthening the Workforce

Recommendation 6: Optimize wages and benefits for professional and direct support workers serving consumers of the public mental health, developmental disabilities and substance abuse service system.

Stakeholders who participated in focus groups reported that low wages and the lack of benefits are two significant factors in the turnover of both professional and direct support workers who serve consumers. This is consistent with national findings. Retention and recruitment of workers into the publicly funded mental health, developmental disabilities and substance abuse services are directly affected by these factors. While this is a long-term endeavor, we recommend that the North Carolina General Assembly explore taking the following actions:

- Increase the wages of direct support workers – The Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services along with other divisions of the NC Department of Health and Human Services, such as the Division of Aging, should work together to support wage increases to all direct support workers in North Carolina so that this group of workers is earning a livable wage.
- Creation of a budgeting mechanism in North Carolina that ensures an annualized cost of living wage increase to direct support workers.
- Creation of a statewide wage incentive program that ties wage increases to demonstration of competence and a comprehensive statewide competence-based training program.

- Creation of mechanisms to provide student loan debt relief for professional and direct support workers in programs serving consumers of public mental health, developmental disabilities and substance abuse services.
- Provision of access to affordable health insurance benefits. Strategies should be developed to organize access to health, dental and life insurance pooled benefits across multiple provider organizations. This may include providing opportunities for professionals and direct support workers to access the State employees' health insurance program.

Recommendation 7: Create selection tools to assist providers in reducing early turnover of workers.

The Department of Health and Human Services in collaboration with provider and advocacy organizations should create job descriptions and selection tools across disability groups and aging that clearly describes the role and responsibilities of direct support workers from the perspective of the worker, giving both positive and challenging aspects of the work. A realistic job preview video is a proven selection tool that successfully recruits workers that remain on the job, thereby reducing rates of turnover. This recommendation includes training for provider organizations on the use of selection tools including the realistic job preview as a component of their selection process. The video and other tools should be made available to all providers of developmental disability, mental health, substance abuse and aging services in North Carolina.

Recommendation 8: Improve access to psychiatric, other medical and non-medical care for individuals served by the public mental health, developmental disabilities and substance abuse service system.

Access to psychiatric, other medical care and non-medical care for consumers of mental health, developmental disabilities and substance abuse services is a high priority in North Carolina. The lack of access to such services, including critical child psychiatry, is an urgent need. The Division of MH/DD/SAS should seek funding to continue to innovate in overcoming existing barriers and addressing current clinical professional workforce shortages. Models that effectively address the recruitment and retention of psychiatric services should be encouraged, such as the following. The Division has implemented some of these strategies.

- Funding to support psychiatric services through LMEs.
- Loan repayment programs and other programs to encourage psychiatrists and other professionals to stay in North Carolina after formal education at our medical and graduate schools.
- Co-location and integration of primary health care and care for consumers of mental health, developmental disabilities and substance abuse services.
- Tele-psychiatry.
- Development of provider models such as those utilized by primary health care for nurse practitioners and physician assistants.
- Funding for state and private training programs for critical shortage specialties must be developed.
- Policies for reimbursement to psychiatric consultants when not working face to face.

Recommendation 9: Create coordinated curricula and credentialing plans for professional and direct support workers.

This recommendation supports the Division in review and revision of mental health, developmental disabilities and substance abuse services rules and policies with intent to develop competency-based staff qualifications at every level. (See appendix D.) Such revision must take into consideration relevant training, education and experience at high school and college levels and of a "grandfather clause" for those with pre-degree work experience. This endeavor would clarify how existing professional licenses match statutory requirements and service definitions and meet supervisory responsibilities. The endeavor would also address the application for both full and part time workers. Such rules would become the basis for applicable curricula and credentialing plans.

Increasing the relevance, effectiveness and accessibility of training and education is directly related to the availability and affordability of up-to-date, comprehensive core curricula for both professional and direct support workers. Such core curricula must be consistent with national and state competencies and credentials. In collaboration with the educational partners, providers' associations, and the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse should assume a lead role in creating coordinated live and online curricula in evidence based and best practices for all levels of professional and direct support workers within the mental health, developmental disabilities and substance abuse services workforce. Models of practical experience must be established such as internships, rotations and field placements.

In addition, there is need for a single credentialing body and program for direct support workers to increase consistency. In collaboration with educational partners, provider associations and the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities and Substance Abuse should assume a lead role in creating an education and training program that recognizes skills and competence of direct support workers through a credentialing program that offers a multi-level career path. The program should include:

- An on-line training opportunity for direct support workers that is competency-based and available and accessible throughout North Carolina communities, that meets national credentialing requirements as appropriate, and that is based on the philosophical and best practice orientation for mental health, substance abuse, developmental disabilities and aging organizations.
- Incentives for direct support workers to complete the education/training program and credentialing program, such as job promotions, career ladders, increased wages or student loan relief for those remain on the job at an organization after completion.
- Inclusion of individuals with disabilities and families as active instructors in the credentialing program that evolves in these organizations.

Recommendation 10: Provide systematic training, technical assistance and incentives to all providers statewide on effective recruitment, retention and training practices.

Educational partners and providers' associations in collaboration with the Division should develop and provide comprehensive training based on the identified competencies to maintain and increase the qualifications of all staff. Activities might include but are not limited to:

- Survey and communication of training opportunities at community colleges and direct support colleges.
- Training and preparation of staff for provision of in-home services to consumers.
- Curriculum in Community Support at community colleges.

Educational partners and providers' associations in collaboration with the Division of MH/DD/SAS should provide training to organizations on evidence-based practices regarding professional and direct support worker recruitment, retention and training. This training should be developed and disseminated throughout the state and target providers of MH, DD and SA and aging services. Interventions taught in this training should include: marketing and recruitment strategies; selection; orientation/socialization; supervisor training; organizational cultural change; competency-based training, and motivation and recognition. In addition, incentives could be explored to encourage organizations to successfully implement such workforce strategies and to offset their increased investment in their workforce.

Recommendation 11: Foster, encourage and support system wide training to frontline supervisors and managers on effective supervision.

Supervision is both an immediate and long-term issue that must be given priority as a means of ensuring the competency, quality and retention of staff. The Division of MH/DD/SAS, providers' associations in collaboration with other training entities in North Carolina should provide system-wide training to supervisors on effective supervision practices to increase their ability to retain employees and increase quality of services. This training should include topics such as: role of a supervisor, professional relationship building, understanding leadership, supervising a diverse workforce, communication, teamwork, performance coaching, conflict resolution, competency based training, employee development, employee motivation and recognition, mentoring and other practices that lead to effective organizational management.

Recommendation 12: In order to create positive work environments, provide opportunities to empower professional and direct support workers serving consumers of publicly funded mental health, developmental disabilities and substance abuse services.

The Annapolis Coalition found that actively fostering leadership development includes identifying leadership competencies and effective leadership curricula, as well as increasing support for formal continuous leadership development in all segments of the workforce.

The Division of MH/DD/SAS in collaboration with all state agencies involved in community human services should ensure that professional and direct support workers are viewed and included as key stakeholders within the system. This includes:

- Opportunities for professional and direct support workers to be at the table when public policy regarding persons receiving mental health, substance abuse, developmental disabilities or aging services is being discussed.
- Provision of financial support for their participation.

- The Direct Care Workers Association of North Carolina (DCWA of NC) should provide statewide and local access to professional association(s) for direct support workers with national affiliations as appropriate.
- Opportunities for direct support workers to network across organizations through statewide conferences for direct support workers.

Appendices

Appendix A. NC Licensing Boards and Governing Statutes and Rules

Appendix B. Generations of Workers

Appendix C. Estimates of Persons in Need of MH/SA Services

Appendix D. North Carolina Administrative Code 10A NCAC 27G .0104 Staff Definitions

Appendix E. Various Maps

Appendix F. Results of Focus Groups on Workforce Issues in Mental Health Systems Transformation in North Carolina, prepared by Behavioral Healthcare Resource Program, July 2007.

Appendix A. NC Licensing Boards and Governing Statutes and Rules

Licensed Professionals	Licensing Boards	Rules and Statutes Governing Licensing
Licensed Psychologists (Doctoral Level of Licensure) **Licensed Psychological Associate** (Master's Level of Licensure)	North Carolina Psychology Board	North Carolina Psychology Practice Act (North Carolina General Statute 90-270, Article 18A) North Carolina Administrative Code (21 NCAC 54)
Psychiatrist	North Carolina Medical Board American Board of Psychiatry and Neurology, Inc. (Certification required from board in order to specialize in a field of psychiatry)	Medical Practice Act (North Carolina General Statute Chapter 90, Article 1) North Carolina Administrative Code (21 NCAC 32)
Licensed Professional Counselors	North Carolina Board of Licensed Professional Counselors	North Carolina Licensed Professional Counselors Act North Carolina General Statute 90, Article 24) North Carolina Administrative Code (21 NCAC 53)
Licensed Clinical Social Worker **Certified Social Work Manager** **Certified Master Social Worker** **Certified Social Worker**	North Carolina Social Work Certification and Licensure Board	North Carolina Social Worker Certification and Licensure Act (North Carolina General Statute 90B) North Carolina Administrative Code (21 NCAC 63)
Licensed Clinical Addictions Specialist (LCAS)	NC Substance Abuse Professional Practice Board	North Carolina Administrative Code 21 NCAC 68

Licensed Professionals	Licensing Boards	Rules and Statutes Governing Licensing
Certified Substance Abuse Counselor (CSAC) **Certified Substance Abuse Prevention Consultant (CSAPC)**		North Carolina General Statute 90-113.32
Qualified Professional		See Staff Definitions in North Carolina Administrative Code (10A NCAC 27G.0104)
Qualified Mental Health Professional		See Staff Definitions in North Carolina Administrative Code (10A NCAC 27G.0104)
Qualified Developmental Disabilities Professional		See Staff Definitions in North Carolina Administrative Code (10A NCAC 27G.0104)
Nurses and Advanced Practice Nurses	NC Board of Nursing	Nursing Practice Act North Carolina Administrative Code (21 NCAC 36)
Qualified Substance Abuse Professional (QSAP) **Qualified Substance Abuse Prevention Professional (QSAPP)**		See Staff Definitions in North Carolina Administrative Code 10A NCAC 27G.0104 See Staff Definitions in North Carolina Administrative Code 10A NCAC 27G.0104

Appendix B. Generations of Workers

William Strauss and Neil Howe in their book, *Generations: The History of America's Future, 1584 to 2069*,[75] posit the history of America as a succession of generational biographies, beginning in 1584 and encompassing everyone through the children of today. Their bold theory is that each generation belongs to one of four types, and that these types repeat sequentially in a fixed pattern.

While the number of years that characterize a generation vary (usually 20 or less years), the main distinction is the way a large group of people handle social conflict. The following provides brief descriptions of four generations that, by 2014, will all be in the workforce together at the same time. This is the first time in the post industrial age that we will have such a diverse workforce. The importance for this document is the additional skills needed by supervisors in working with a mix of staff from different generations.

- Baby Boomers - These are the idealists and "prophets" that were born at a time when society was in high social conflict (unraveling of norms). Baby boomers are cerebral, principled, and able to summon and commit human sacrifice, righteous; combat has been seen by a few; their words and deeds coincide. Baby boomers were the innovators of computer technology. They are the "us" generation and will be 50 years or older by the year 2014.

- Generation X - These are the nomads. Gen-X children were the first raised by two parent incomes. They were the latch-key kids; they tend to have no sense of attachment; and, as adults, they tend to move the furthest from home. They will likely experience mid-life crises but in old age, they may experience a new high. They are cunning, hard to fool, tactical but not strategic, assertive and don't like to deal with conflict in mass (but will confront an individual one-on-one). They are the "me" generation and they live in the mainstream of computer technology. They are the first generation to embrace business as a major and they were raised largely by "Reaganomics."

- Generation Y – This generation gets their name from the question they most ask: Why? Gen-Y feels as if they have been sold a bill of goods; they believe that the sky is the limit in terms of power, money, and success but they never knew that they must wait for their turn. They are knowledgeable; skilled and tech-savvy. They are in their 20's right now. They are civic-minded, vigorous, and institution-builders; they like to be busy and competent; they are advocates of technology and show public optimism. They are ridiculously romantic (e.g., "I applied online so of course they have my application!"). They use instant messaging, blackberries and don't know why others don't want them to use these gadgets. They lack problem solving skills and over rely on technology.

[75] Howe and Strauss, *Generations: The History of America's Future 1584 t 2069*, Harper Perennial, 1991.

Negotiating with Gen-Y is difficult. Gen-Y is the first group to say "no" to business (e.g., "I refuse to be on call 24/7." "I demand a balanced life and employers must respect my rights.").

- Traditionalists - Born during crisis. They become leaders who advocate fairness. They learned how to use technology. They made negotiation into an art form. They want small projects to renovate the world. Global thinkers.

Appendix C. Estimates of Persons in Need of MH/SA Services

Calculating the estimated number of persons in need of mental health or substance abuse services per licensed professional by county provides a general estimate of potential caseload for each type of professional by county. This information may be useful in evaluating the potential adequacy of the numbers and distribution of these professionals across the state for workforce development purposes.

Note that the same approach is used to estimate the number of persons who experience developmental disabilities and who need services and supports. Without information about the numbers and distribution of staff working with these consumers, no estimates were provided for this report. For additional information, see the Division's *Semi-Annual Report to the Joint Legislative Oversight Committee on MH/DD/SAS* on statewide system performance.[76]

Estimates of persons with substance abuse disorders, children with Serious Emotional Disturbance (SED), and adults with Serious Mental Illness (SMI) in North Carolina by county in 2006 were calculated by multiplying the latest available state-wide prevalence rate for the indicated age group by the projected number of persons in the county in that age group.

[Estimated Number of Persons In Need of Services = Statewide Prevalence Rate x County Population]

Population projections for July 1, 2006 came from the State Demographics Unit website (http://demog.state.nc.us). These numbers were the latest available at the time this document was prepared (December 6, 2006).

Estimates of persons with SED/SMI were based on the latest available published prevalence rates for North Carolina prepared for the Center for Mental Health Services (CMHS) by the National Association of State Mental Health Program Directors Research Institute (NRI) State Data Infrastructure Coordinating Center (SDICC), August 29, 2006, for the Mental Health Block Grant.

- The prevalence rate for children (12%) came from URS Table 1: Children with Serious Emotional Disturbance, ages 9-17, by State, 2005. It should be noted that 12% is the midpoint (11%-13%) for the LOF=60 range (SED with substantial functional impairment). This percentage was applied to all children.
- The prevalence rate for adults (5.4%) came from URS Table 1: Number of Persons with Serious Mental Illness, ages 18 and older, by State, 2005.

Estimates of persons with substance abuse disorders were based on the latest available published prevalence rates for North Carolina prepared by SAMHSA, Office of Applied Studies, from the National Surveys on Drug Use and Health, 2003 and 2004.

[76] See: Semi-Annual System Performance Reports at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

- The prevalence rate for youth ages 12-17 (7.24%) and adults ages 18-25 (17.30%) and ages 26 and older (6.26%) came from Table C.20 Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year, by Age Group and State, persons with a SA Disorder in 2003-2004.
- This resulted in an overall prevalence rate for persons ages 12 and older in NC of 7.79%.

Cautionary Note: The estimated numbers of consumers per licensed mental health or substance abuse professional in the maps are unadjusted numbers. A number of factors can affect the calculation and cause the actual number of consumers per professional to vary from the numbers shown. For example, not all persons in need of services necessarily seek services, and not all licensed professionals actually provide clinical services. Some persons in need of services may never seek services, and some licensed professionals may work in an administrative capacity or in a non-clinical setting. In addition, while it is generally believed that licensed professionals with addresses in a particular county most likely work in that county, it is possible that some of these professionals may actually work elsewhere. Similarly, some persons in need of services who live in one county may actually seek services in another county.
With these cautions in mind, the information provided on these maps should still be useful for workforce development purposes for evaluating the potential adequacy of the numbers and distribution of mental health and substance abuse professionals across the state.

Appendix D. Current Applicable MH/DD/SAS Rules

10A NCAC 27G .0104 STAFF DEFINITIONS

The following credentials and qualifications apply to staff described in this Subchapter:

(1) "Associate Professional (AP)" within the mental health, developmental disabilities and substance abuse services (mh/dd/sas) system of care means an individual who is a:

(a) graduate of a college or university with a Masters degree in a human service field with less than one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(b) graduate of a college or university with a bachelor's degree in a human service field with less than two years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(c) graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional with less than four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(d) registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mh/dd/sa with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

(2) "Certified alcoholism counselor (CAC)" means an individual who is certified as such by the North Carolina Substance Abuse Professional Certification Board.

(3) "Certified drug abuse counselor (CDAC)" means an individual who is certified as such by the North Carolina Substance Abuse Professional Certification Board.

(4) "Certified clinical supervisor (CCS)" means an individual who is certified as such by the North Carolina Substance Abuse Professional Certification Board.

(5) "Certified substance abuse counselor (CSAC)" means an individual who is certified as such by the North Carolina Substance Abuse Professional Certification Board.

(6) "Certified substance abuse prevention consultant (CSAPC)" means an individual who is certified as such by the North Carolina Substance Abuse Professional Board.

(7) "Clinical" means having to do with the active direct treatment/habilitation of a client.

(8) "Clinical staff member" means a qualified professional or associate professional who provides active direct treatment/habilitation to a client.

(9) "Clinical/professional supervision" means regularly scheduled assistance by a qualified professional or associate professional to a staff member who is providing direct, therapeutic intervention to a client or clients. The purpose of clinical supervision is to ensure that each client receives treatment or habilitation which is consistent with accepted standards of practice and the needs of the client.

(10) "Clinical social worker" means a social worker who is licensed as such by the N.C. Social Work Certification and Licensure Board.

(11) "Director" means the individual who is responsible for the operation of the facility.

(12) "Licensed professional counselor (LPC)" means a counselor who is licensed as such by the North Carolina Board of Licensed Professional Counselors.

(13) "Nurse" means a person licensed to practice in the State of North Carolina either as a registered nurse or as a licensed practical nurse.

(14) "Paraprofessional" within the mh/dd/sas system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a mh/dd/sa service. Supervision shall be provided by a qualified professional or associate professional with the population served. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

(15) "Psychiatrist" means an individual who is licensed to practice medicine in the State of North Carolina and who has completed a training program in psychiatry accredited by the Accreditation Council for Graduate Medical Education.

(16) "Psychologist" means an individual who is licensed to practice psychology in the State of North Carolina as either a licensed psychologist or a licensed psychological associate.

(17) "Qualified client record manager" means an individual who is a graduate of a curriculum accredited by the Council on Medical Education and Registration of the American Health Information Management Association and who is currently registered or accredited by the American Health Information Management Association.

(18) "Qualified professional" means, within the mh/dd/sas system of care:

(a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mh/dd/sa with the population served; or

(b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

(19) "Qualified substance abuse prevention professional (QSAPP)" means, within the mh/dd/sas system of care:

(a) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated supervised experience in substance abuse prevention; or

(b) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated supervised experience in substance abuse prevention; or

(c) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post bachelor's degree accumulated supervised experience in substance abuse prevention; or

(d) a substance abuse prevention professional who is certified as a Certified Substance Abuse Prevention Consultant (CSAPC) by the North Carolina Substance Abuse Professional Certification Board.

History Note: *Authority G.S. 122C-3; 122C-25; 122C-26; 143B-147;*
Eff. May 11, 1996;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Temporary Amendment Eff. November 1, 2001;
Amended Eff. October 1, 2004; April 1, 2003.

10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS

(a) There shall be no privileging requirements for qualified professionals or associate professionals.

(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.

(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.

(d) Competence shall be demonstrated by exhibiting core skills including:

(1) technical knowledge;

(2) cultural awareness;

(3) analytical skills;

(4) decision-making;

(5) interpersonal skills;

(6) communication skills; and

(7) clinical skills.

(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.

(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.

(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.

History Note: Authority G.S. 122C-26;
Temporary Adoption Eff. January 1, 2001;
Temporary Adoption Expired October 13, 2001;
Temporary Adoption Eff. November 1, 2001;
Eff. April 1, 2003.

10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS

(a) There shall be no privileging requirements for paraprofessionals.

(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.

(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.

(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.

(e) Competence shall be demonstrated by exhibiting core skills including:

(1) technical knowledge;

(2) cultural awareness;

(3) analytical skills;

(4) decision-making;

(5) interpersonal skills;

(6) communication skills; and

(7) clinical skills.

(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.

History Note: Authority G.S. 122C-26;
Temporary Adoption Eff. January 1, 2001;
Temporary Adoption Expired October 13, 2001;
Temporary Adoption Eff. November 1, 2001;
Eff. April 1, 2003.

Appendix E. Various Maps

North Carolina Economic Regions

Economic Regions

- Advantage West
- Carolina's Partnership
- Global Transpark Region
- North Carolina's Northeast
- North Carolina's Southeast
- Piedmont Triad Partnership
- Research Triangle Regional Partnership

Source: NC Dept. of Commerce

This map displays the economic regions that counties are organized into for North Carolina. The regions operate in partnerships for economic development. Regions compete for new investments and devise effective economic development strategies based on local and regional opportunities and advantages.

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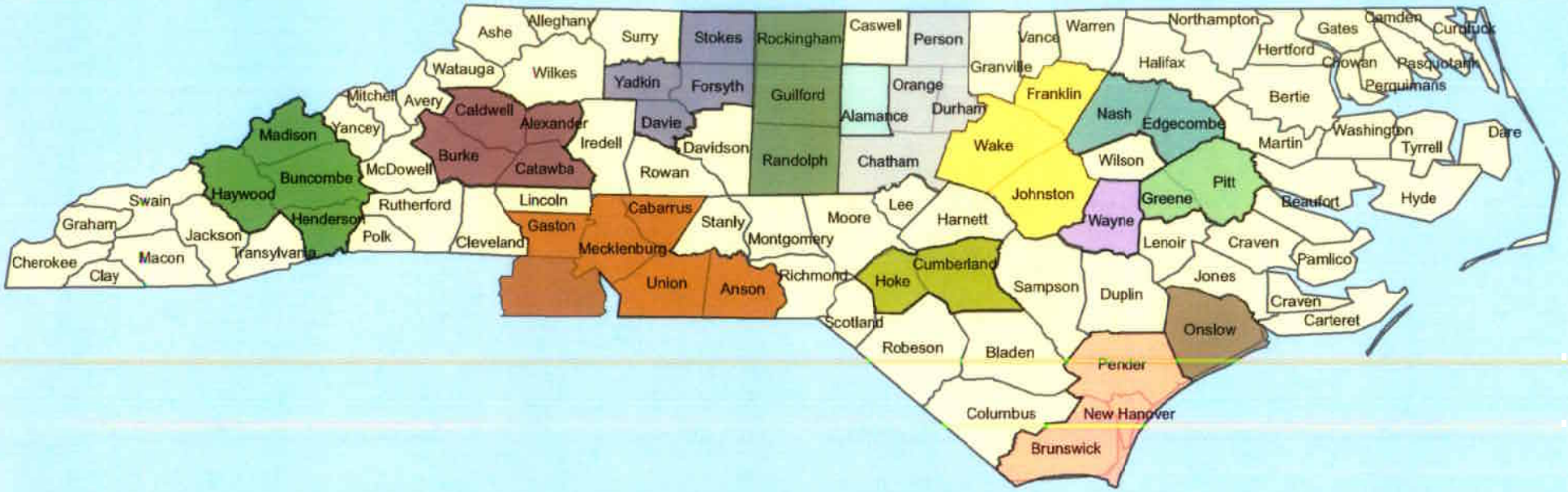
North Carolina Metropolitan Areas



NC Metro Areas

Metro Regions

- Asheville, NC
- Burlington, NC
- Charlotte-Gastonia-Concord, NC-SC
- Durham, NC
- Fayetteville, NC
- Goldsboro, NC
- Greensboro-Hight Point, NC
- Greenville, NC
- Hickory-Lenoir-Morganton, NC
- Jacksonville, NC
- Raleigh-Cary, NC
- Rocky Mount, NC
- Wilmington, NC
- Winston-Salem, NC

Source: Census 2000

United States metropolitan areas are defined by census data. The most recent metro areas are established as of Census 2000 data and were announced as of June 2003. The US Office of Management and Budget (OMB) defines metropolitan and micropolitan statistical areas as containing a substantial population center, together with adjacent communities having a substantial integration with the population center.

Source: US OMB

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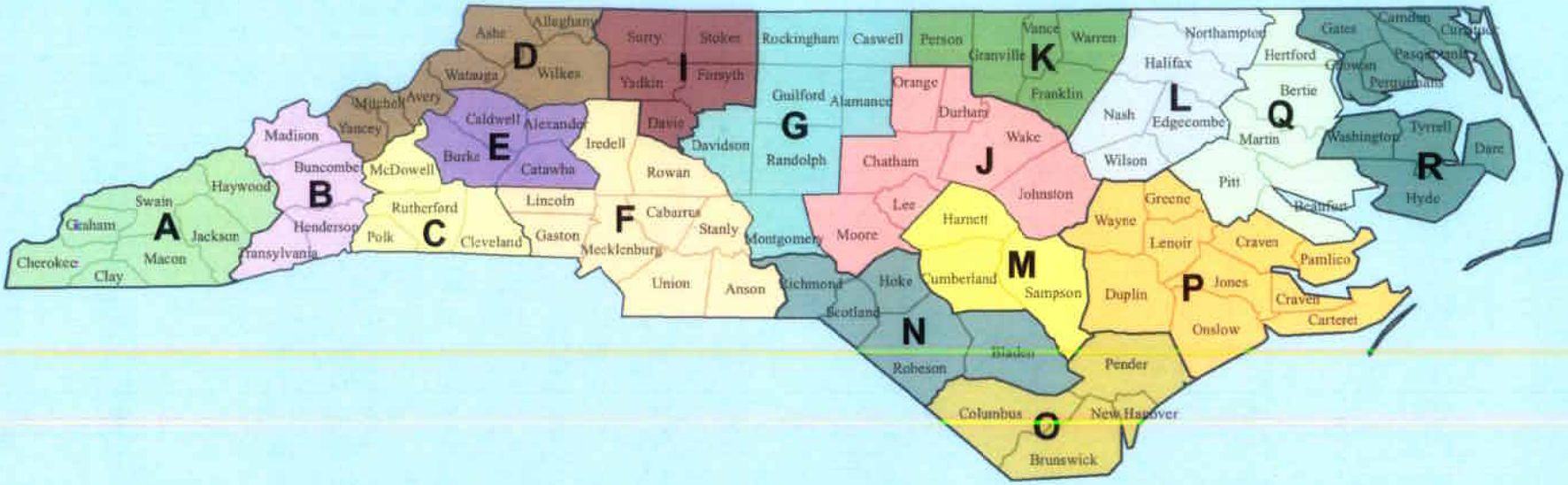
North Carolina Councils of Governments



Regional Councils of Governments

Name of Council or Commission

- A - Southwestern Comm.
- B - Land-of-Sky Regional Council
- C - Isothermal Planning and Development Comm.
- D - High Country CoG
- E - Western Piedmont CoG
- F - Centralina CoG
- G - Piedmont Triad CoG
- I - Northwest Piedmont CoG
- J - Triangle J CoG
- K - Kerr-Tar Regional CoG
- L - Upper Coastal Plain CoG
- M - Mid-Carolina CoG
- N - Lumber River CoG
- O - Cape Fear CoG
- P - Eastern Carolina CoG
- Q - Mid-East Comm.
- R - Albemarle Comm.

Source: Wikipedia 2005

Councils of governments and regional councils are voluntary associations of local and regional governments that coordinate efforts to organize economic development, land use planning, and environmental protection.

Source: US Census Data (2000)

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North Carolina MH/DD/SAS Workforce Analysis Project

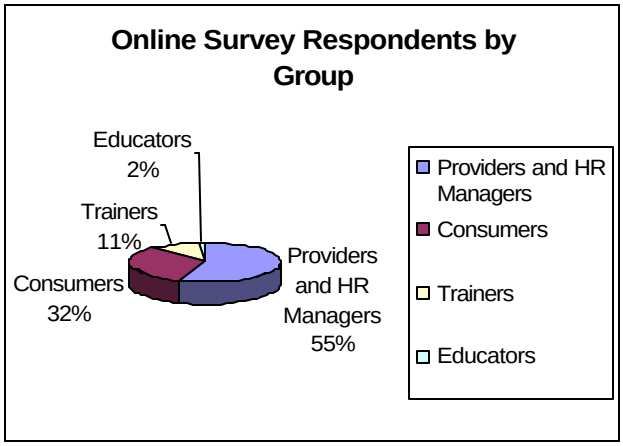
Conducted by
Behavioral Healthcare Resource Program
School of Social Work
University of North Carolina at Chapel Hill

August 2007

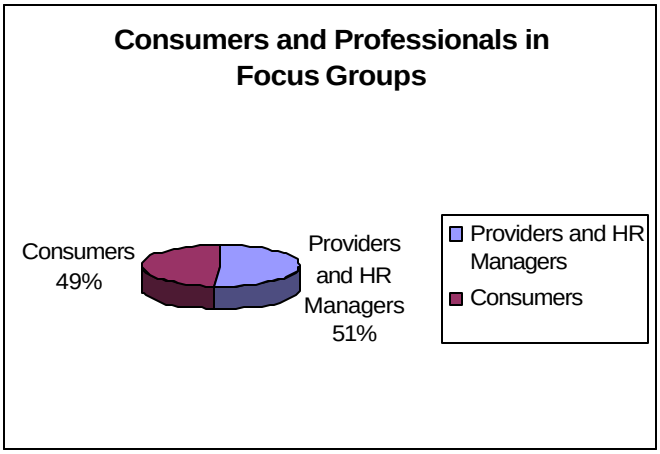
Executive Summary

In February 2007, the NC Commission and the NC Division of MH/DD/SAS requested the Behavioral Healthcare Resources Program (BHRP) in the School of Social Work at the University of North Carolina at Chapel Hill administer surveys and conduct focus groups across the state to determine key workforce issues facing stakeholders.

Surveys were developed for four stakeholder groups—providers and human resource (HR) managers, consumers, trainers, and educators. While some of the questions were the same across the survey respondents and focus group participants, some items were specific to the concerns of each particular stakeholder group. Questions asked by category of respondent are listed in Appendix A for the online survey and Appendix B for the focus groups. A total of 117 persons responded to the online survey. The percentages by survey category are shown in the chart below.



BHRP staff members conducted focus groups of consumers in Asheville, Chapel Hill, Charlotte, Greenville, and Wilmington and of providers and HR managers in Asheville, Chapel Hill, Charlotte, Fayetteville, and Wilmington. Seventy-two people participated in the focus groups. The chart below shows percentages in the 2 types of groups.



For both surveys and focus groups, the evaluator analyzed the content in order to examine themes identified by both methodologies. As noted above, surveys were conducted online using www.surveymonkey.com so responses were downloaded into excel files and then converted into word files for ease in coding. Focus groups were taped, and the tapes were transcribed into excel spreadsheets. These files were also converted into word files. For both surveys and focus groups, the content analysis procedure consisted of coding and tallying identified themes. Themes were based on the questions. Survey responses and focus group transcriptions were read thrice, prior to coding, after coding, and during the write-up, to ensure that the recurring themes were identified and that all information was coded. Coding into these themes or content categories by specific words or patterns then occurred.

A review of the issues indicates that:

- stakeholders agree that providers needed training on evidence-based practices, cultural competency, disability-specific behavioral interventions, clinical documentation, and writing person-centered treatment plans;
- that recent hires needed more real-world experience;
- that professionalism and providers' respect for consumers and frontline workers was lacking;
- and that increasing paperwork, regulations, and system changes were taking their toll.
- Staff turnover, an insufficient number of providers and supervisors, underpaid and undervalued staff, and unqualified staff were also of concern.
- Consumers identified access to services as essential, and discussion focused on inadequacies within the system.
- Providers found that access to training was problematic (e.g., cost, timing, location) and that licensing requirements were worrisome due to their implications on supervision and billing.
- What is particularly distressing is a continued lack of understanding about Mental Health Systems Transformation.
- Also missing was a widespread understanding of the importance of implementing evidence-based interventions (less than one-third of respondents identified it as critical).

A number of solutions were identified:

- Marketing was suggested—to inform consumers and providers about Mental Health Systems Transformation, including information about billing and reimbursement and a listing of community resources in each service area.
- Also important was the need to provide job descriptions with explicit expectations so that potential employees were realistic about staff requirements.
- To increase applicant fit with the agency and to decrease turnover, screening of staff was suggested as a possible remedy.
- Training of staff was identified as critical, with opportunities for advancement needed. Suggestions addressed pre-service education, continuing education, educational assistance, training on specific topics, mentoring, and high-quality supervision.

Background

In February 2007, the NC Commission and the NC Division of MH/DD/SAS requested the Behavioral Healthcare Resources Program (BHRP) in the School of Social Work at the University of North Carolina at Chapel Hill administer surveys and conduct focus groups across the state to determine key workforce issues facing stakeholders.

Surveys were developed for four stakeholder groups—providers and human resource (HR) managers, consumers, trainers, and educators. While some of the questions were the same across the survey respondents and focus group participants, some items were specific to the concerns of each particular stakeholder group. Surveys were developed in March and administered beginning in April, 2007 and ending in June, 2007. The link to the online surveys were sent to email addresses of providers, educators, trainers and consumers primarily generated from the Division's endorsed provider database. Approximately 11,000 unique email addresses were sent to encourage responses to the online survey instruments. Surveys were uploaded to www.surveymonkey.com, and the evaluator downloaded the databases for data analysis. Sixty-five providers and HR managers, 37 consumers, 13 trainers, and 2 educators completed the online surveys (total of 117 respondents). See Table 1 below for the number of survey participants by instrument.

Table 1
Online Survey Respondents by Group

Respondent Group	Number of Respondents
Providers & HR Managers	65
Consumers	37
Trainers	13
Educators	2
Total	**117**

BHRP staff members conducted focus groups of consumers in Asheville, Chapel Hill, Charlotte, Greenville, and Wilmington between April 25 and May 30 and of providers and HR managers in Asheville, Chapel Hill, Charlotte, Fayetteville, and Wilmington between May 3 and May 30 (see Table 2 below for the number of focus group participants). The audiotapes of these focus groups were transcribed and forwarded to an external evaluator, who conducted a content analysis of the transcripts.

Table 2
Number of Consumers and Professionals in Focus Groups

Location	Consumers	Providers/HR Managers
Asheville	4	9
Chapel Hill	6	8
Charlotte	14	4
Fayetteville	0	9
Greenville	1	0
Wilmington	10	7
Total	**35**	**37**

For both surveys and focus groups, the evaluator analyzed the content in order to examine themes identified by both methodologies. As noted above, surveys were conducted online using www.surveymonkey.com so responses were downloaded into excel files and then converted into word files for ease in coding. Focus groups were taped, and the tapes were transcribed into excel spreadsheets. These files were also converted into word files. For both surveys and focus groups, the content analysis procedure consisted of coding and tallying identified themes. Themes were based on the questions. Survey responses and focus group transcriptions were read thrice, prior to coding, after coding, and during the write-up, to ensure that the recurring themes were identified and that all information was coded. Coding into these themes or content categories by specific words or patterns then occurred.

In the succeeding pages, results from the surveys are presented first—those completed by providers and HR managers, consumers, trainers, and educators. Results from the focus groups then follow, with consumers presented first, then providers and HR managers.

Online Surveys

Surveys of Providers and Human Resource (HR) Managers (n=65)

On what topic areas do recent graduates need further training (e.g., evidence-based practices) (n=64)?

- Evidence-based practices (EBPs) (21 comments) topped the list for providers and HR managers. Specific EBPs mentioned included dialectic behavioral therapy (DBT) (3), cognitive-based therapy (CBT) (3), motivational enhancement therapy (MET) (1), brief interventions (1), cannabis youth treatment (CYT) (1), assertive community treatment teams (ACTT) (1), and eye movement desensitization and reprocessing (EMDR).

- Also frequently cited were person-centered thinking or writing person-centered plans (13), clinical documentation (12), North Carolina Reform, including service definitions and navigating the Division's website (5), HIPAA and confidentiality (5), crisis intervention (5), assessment (5), diagnosis including DSM IV (4), system of care (4), more practical field experience in a variety of settings and with diverse clientele (4), writing measurable goals and outcomes (3), professionalism including boundaries (3), group therapy (3), and substance abuse (3).
- Providers and HR managers mentioned the following topics, twice each: clinical supervision, co-occurring disorders, what services are available, community supports, understanding funding sources and maintenance of services, communication skills, relationship development, child/family team building, and writing and math.
- They mentioned the following topics once each: Federal and state mandates, rules, and regulation; paperwork; risk assessment; suicide assessment; case management; clinical thinking skills; skill building; training on specific populations with which they will be working; cross-training on the three disabilities; Methadone; serious and persistent mental illness; personality disorders; psychopathology; working with professionals in other fields; DSS practices; caregiver training; better quality improvement training; long-term chronic illness and effects of stress and grief; fundamentals of HCBS waivers; understanding Medicaid/insurance wording; community resources; development of natural supports; how to meet licensure requirements; counseling skills; role playing; active listening; anger management; cultural competency; people skills; problem solving; conflict resolution; time management; working in changing systems; accounting; legal issues; doing a thorough and high quality job in all aspects of treatment; working with multidisciplinary teams; family dynamics; and social justice.
- A provider recommended that students take the licensing exams during their last semester and apply for provisional licensure so that they can be employed as soon as they graduate.

In what ways should pre-professionals be educated about job responsibilities and careers in the public sector (n=61)?

- Providers suggested that preprofessionals receive intensive training while on the job (8 comments);
- an overview of roles and responsibilities of managers, supervisors, clinicians, and frontline workers in different settings and challenges facing the field (7);
- practicums/internships (5);
- higher education (4); mentoring (2); supervision (2); consultation/coaching (2); job shadowing (1); case management (1); site rotations (1); skill building (1); researching a day in the life of a human services agency (1); interviewing three past graduates (1); and learning the expectations of state and local governments (1).

- A significant number of respondents did not suggest ways that preprofessionals should be educated about public sector careers; rather, they suggested more topics on which to train.

In what ways do you currently collaborate with institutions of higher education (n=62)?

- Eighteen providers and HR managers (18) stated that they either offer practicums/ internships or serve as a field placement supervisor;
- Eleven (11) said that they attended trainings that the schools offered, and
- Five (5) indicated that they recruited there.
- Other responses included the following: participate in a research study (2 comments); conduct career fairs (2); present in their classes (1); hire their graduates (1); advise clients on programs in community colleges and universities (1); have their faculty conduct in-services (1); use their library facilities (1); use their training resources (1); utilize their technology assistance (1); offer students the opportunity to job shadow (1); and refer clients to the university's counseling center (1).
- Twelve respondents said they did not currently collaborate with institutions of higher education.

What is the biggest barrier in offering practicum experiences to pre-professional students (n=64)?

- At the top of the list was the amount of time needed to supervise and mentor students (15 comments).
- Providers and HR managers also identified staff capacity (8),
- Inability to bill for students' services (7),
- Lack of payment for students (5), lack of funding (5), clinical supervision support needed for students (4), space (4), lack of experienced students (3), scheduling so that students could meet with clients (3), and confidentiality/ liability issues (3) as barriers.
- Mentioned twice each were the barriers of a limited number of sites, the short period of time of the internship, the need to educate professionals about the benefits of supervising students, and the location of the internship site.
- Providers and HR managers also identified the following barriers (once each):
    - no list of approved sites, need for the educational level of the supervisor to match that of the student, computer access, lack of knowledge of current coursework to enhance the field experience, supervision requirements differing among disciplines, student unfamiliarity with service definitions, and internal politics.

As HR managers, what are the greatest strengths of recent hires? Limitations? How can institutions of higher education address these limitations (n=57)?

Strengths of recent hires included the following:

- education (5)
- eager to learn/work (5)
- enthusiasm (5)
- passionate (5)
- fresh ideas (4)
- energy (4)
- willing to learn new things (3)
- computer literacy (3)
- excellent experience (2)
- new way of looking at situations/problems (2)
- open-minded (2)
- willing to care for and work with target populations (2)
- good knowledge of EBPs (2)
- good clinical skills (2)
- good knowledge of social work (1)
- training in psychopharmacology (1)
- ability to follow instructions (1)
- free labor (1)

Limitations of recent hires included the following:

- Lack of experience (21 comments), which included a lack of understanding of real-world practice (2), how MH positions function in the field (2), working with families (1), suicide assessments (1), funding sources and how they relate to families (1), billing (1), paperwork (1), and office politics (1).
- Lack of knowledge (e.g., treatment team process) (6), which included a lack of awareness of where services are provided—in the community, not the office (1); knowledge of substance abuse work (1); knowledge of group therapy (1); and understanding of legal issues (e.g., subpoenas, confidentiality) (1).
- Lack of professionalism (6)
- Insufficient training (3)
- Unrealistic expectations about promotion/salaries (3)
- Poor communication (e.g., writing and math) skills (3)
- Unable to use computers (2)
- Learning curve (1)
- Not prepared to address real-life issues that consumers face (1)
- Adjusting to new work culture (1)
- Poor organizational skills (1)
- Lack of maturity (1)
- Easily overwhelmed (1)

- Lack of humility (1)
- Unmotivated (1)
- Too much time spent on the Internet so not enough critical thinking (1)
- Inability to multi-task (1)
- Job hopping (1)
- Negative criminal background checks and negative urine screens (1)

Other limitations cited related to the workplace, not the recent hires. These limitations included the supervision requirements for licensure and certification (5), lack of clinical supervisors (2), poor salaries (1), lack of benefits (1), lack of resources to help new hires receive the training that they need (1), an inadequate number of nurses, CSACs on ACT teams, and psychiatrists (1), and a lack of guidance from DMA and DHHS.

Providers and HR managers were also asked to suggest possible ways that institutions of higher education (IHE) could address the limitations.

- The nurturing and requirement of diverse clinical experience was cited by six providers and HR managers. They also thought that IHEs should teach empathy and respect of different lifestyles and priorities (3 comments), expectations of roles and responsibilities and realities of actual practice (3), billing and implications for developing treatment plans (2), licensing requirements (2), and professionalism (2). Providers and HR managers also encouraged IHEs to partner with treatment agencies (2) and suggested that IHEs require basic education in substance abuse treatment in the core curriculum and more education on the efficacy of group interventions (1); prepare students for working as a team member (1), place a greater emphasis on clinical documentation (1), socioeconomic diversity (1), and confidentiality (1); assign more work in journals; and require pre-hire job shadowing (1). Another suggested that IHEs provide a waiver on GPA or GRE scores and accept students provisionally in order for professionals to pursue advanced degrees.

What is the biggest barrier in hiring recent graduates of master's level programs (e.g., supervision, licensure) (n=60)?

- Twenty-two providers and HR managers identified the biggest barrier in hiring recent graduates as licensing requirements for billing. Corresponding to this barrier was the fact that consistent supervision is needed as part of the licensing requirement and there is a dearth of qualified supervisors (14) and that recent hires lack the necessary experience (10).
- Other barriers included unrealistic expectations of positions they can hold and the salary range (6); the lack of adequate salaries (5); the lack of licensure (5); the unattractiveness of rural areas to recent graduates (5); unrealistic expectations as to what can and cannot be done (3); system reform (3); a poor work ethic (2); the slow licensure process (1); degrees of recent graduates may not meet staffing requirements (1); non-reciprocating graduate degrees from other states (1), the lack of appropriate coursework in graduate programs (1);

recent graduates needing an adequate learning curve (1), and maintaining resilience (1).

How does licensure affect your decisions in hiring recent graduates (n=57)?

- Respondents were divided on this question. Twenty-eight providers and HR managers thought that licensure greatly affected hiring decisions while others identified the barriers as the lack of supervision (1) and the lack of experience (1). Some providers thought that licensure assured a certain level of competence and made the candidates more desirable (3) although one disagreed, stating that licensure did not guarantee that they were the best qualified. Still others thought it did not affect their decision (5) or were unclear whether there was an effect (1). One provider noted that his/her agency now requires that employees have a year of experience with the population served since new hires lacked the necessary knowledge and skills. Ten stated that the question was not applicable to their situation.

What skill set is needed to sustain a workforce (e.g., evidence-based practices, cultural competency) (n=59)?

According to survey results of providers and HR managers, the top two were evidence-base practices (21 comments) and cultural competency (21). They also identified the following skill sets:

- Professionalism, including boundaries, ethics (6)
- Experience (4)
- Understanding the populations that they work with (4)
- Documentation skills (4)
- Therapeutic skills (4)
- Compassionate (4)
- Person-centeredness philosophy (3)
- Communication skills (3)
- Ability to be flexible (3)
- People skills (2)
- Ability to complete paperwork correctly and on time (2)
- Knowledge of business aspects (2)

Providers and HR managers identified each of the following skill sets once: diagnosis, values and ethics, work ethic, case management, interviewing skills, knowledge of family dynamics, group therapy skills, substance abuse knowledge, being accountable, consistent, knowledge of the language of managed care, first aid and CPR, ability to work as a member of a treatment team, ability to work cooperatively with other community partners, bilingual, problem-solving skills, fast learner, tolerant, time management skills, and stress management skills.

While two respondents thought it critical for providers to know EBPs, he/she felt strongly that funding for required training be available and that they not be penalized for attending the training (e.g., meeting productivity goals or taking time off). Another provider requested guidelines from the state regarding community support services and how it differed from case management and community-based services. Yet another thought that the focus was not on a skill set *per se* but on the agency as a whole—its "programs, services, culture, opportunities, consistency, training, advancement, compensation, benefits, location, etc."

Providers thought that training should be ongoing (4 comments). They also recommended higher salaries (2) and benefits (1).

How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis) (n=52)?

- The respondents identified the person-centered approach as an appropriate strategy for meeting the needs of special populations.
    - For the online survey, providers and HR managers identified this approach 17 times.
    - Other strategies included provide training (11), refer to other providers who can meet those special needs (7), use supervision to monitor treatment for these groups (4), recruit staff with competence in these areas (4), conduct assessment to determine needs (3), match staff with clients (3), offer special programming (3), address issues of diversity through appropriate groups and individual sessions (2), obtain consultation (2), follow state definitions and guidelines (2), demonstrate sensitivity (1), utilize resources in these areas (1), use developmental model for children (1), and work to diversify the workforce (1).

One respondent noted that his/her agency conducts an annual review of populations served and their success rates before determining what training is needed and what cases should be referred (1). Another provider noted that decreased funding and fewer training opportunities have made it more difficult to meet the needs of special populations (1). Voicing a similar sentiment, a respondent stated that developing highly specialized programs is time consuming and costly with insufficient reimbursement to cover the associated expenses (1).

What training/support is needed for personnel (direct care and professional) (n=58)?

Training in general was noted as a need by seven respondents (7). Specific training needs included:

- documentation (9 comments);
- self-care such as coping with stress and compassion fatigue (6);
- skill building (5); HIPAA, ethics, and confidentiality (5);

- state reform (4); evidence-based practices (4); writing person-centered plans (4); communication skills (4);
- special populations (3);
- writing goals (2); hands-on experience/shadowing before engaging in work (2); substance abuse (2); supervision (2); crisis response (2); incident reporting and risk control training (2); and community support (2).
- Additional topics, mentioned once each, included the following: diagnosis, writing skills, service definitions, CBT training, psychopathology, personality disorders, homelessness, child/family teams, direct care, group therapy, cultural competency, clients' rights, language of managed care, use of the electronic record, identifying and reporting abuse and neglect, rules and regulations related to human resources, interviewing skills, observation skills, being empathic and non-judgmental, recognizing and resolving personal bigotry, assertiveness training, and Spanish.

Providers and HR managers also identified ways in which support could be offered.

- At the top of the list were financial incentives (1),
    - Free or affordable and locally accessible training (6 comments), better salaries (1), improved benefits (1), continuing education reimbursement (1), and pay for educational time.
    - Good clinical supervision, including peer supervision, was also desired by nine respondents.
    - Similar to this suggestion were access to consultation with experienced clinicians (2 comments), mentors (1), and licensed clinicians (1).
    - Also mentioned, once each, were oversight, support, reduced paperwork requirements, the availability of online training, a doctoral program for working professionals, good communication from top down and bottom up, less micromanagement by managers, the hiring of support staff, resources for consumers, and increased funding to bolster services.

What recruitment strategies/activities could be used to build the workforce (n=52)?

Providers and HR managers identified the following recruitment strategies:

- Post job openings in professional journals, professional meetings, websites, and at IHEs (11);
- Offer compensation and benefits/incentives packages (8);
- Conduct job fairs (7);
- Partner with IHEs and professional organizations (4);
- The state needs to give private providers incentives (e.g., funding for recruitment, orientation, and training) (2); provide realistic role expectations in the field (2); offer loan forgiveness programs (2).
- Additional strategies that were identified, once each, included offer job sharing or 10-month positions; hire more diverse staff; provide compensation for bilingualism, biculturalism, and field specialization; develop a career path; assign a mentor upon hiring; do not expect or allow overtime; do not charge income taxes for those who work in human services; offer psychoeducation and skills-

building programs; reduce regulations and fees associated with certification and licensure; increase reciprocity across states; ensure that your community-based agency is highly respected; and provide grant funding.

What incentives or retention strategies should be instituted (n=54)?

Providers and HR managers most frequently cited

- Financial incentives as retention strategies,
    - with higher, competitive salaries (15 comments) and
    - better benefits including retirement (13) heading the list.
- Other financial incentives included merit pay and raises (8); bonuses (7); educational assistance for degree programs, licensure, and certification (7);
- Loan forgiveness programs (4); hiring bonuses (1); a way for new hires to produce revenue to cover their salaries (1); increase in salary with licensure (1); compensation for completing paperwork (1); travel reimbursement for home visits (1); and incentives to stay at an agency for *x* amount of time (1).

They also suggested the following retention strategies:

- Ongoing training (9); opportunities for advancement,
- Create a career ladder (6);
- Clinical supervision including ongoing feedback and consultation (4); direct recognition of individual quality work (4); work environment stability and reliable management (3); flexible scheduling including a four-day work week (2); strengthening relicensing requirements (1); loosening state mandates to allow for real treatment to take place (1); matching provider strengths/skills with consumers' needs (1); the freedom to be creative (1); encouraging research and other professional development practices (1); more support from administrative staff (1); self-care opportunities (1); access to effective tools to complete their jobs well (1); full access to technology and equipment (1); the reduction of paperwork (1); and an agency mission statement of helping the staff be the best that they can be (1).

What solutions can be shared to address the challenges in building/sustaining a competent workforce (n=46)?

Answers were analyzed into four categories—state, local, staff, and training.

At the state level, providers of the online survey stated

- Their desire for less chaos and more stability in the system (3 comments); consistency and better communication from the state to providers (2); an increase in funding for hiring more skilled staff and to pay for EBPs (2); an improvement of the recognition of behavioral health as medical service (1); parity of insurance (1); and a reduction in stigma related to substance use and mental disorders (1).

At the local level, two respondents proposed that

- Agencies assess their applicants' strengths and hire based on fit and what is needed at the agency (2 comments) and
- A reduction in paperwork (2).
- Additional suggestions, once each, included a stable work environment; interagency collaboration and sharing; encouraging providers to attend training on clinical supervision; constructive evaluation of staff on performance or outcomes by appropriate supervisor; a contracted consultant to assist staff determine personality type with implications for work at the agency; a need for diverse HR personnel; encouraging interagency collaboration; and holding a managers meeting with staff daily before the work day begins.

At the staff level,

- Financial incentives again led the number of suggestions: merit raises (4), competitive salaries (3), reimbursement for continuing education (3), merit pay (2), opportunities for advancement and professional growth (2), a provision of incentives to providers to ensure they will stay in the field (1), better benefits (1); and payment of experienced staff to mentor new hires (1).
- Providers and HR managers also suggested that administrators and managers demonstrate the value of the providers to them (2), provide morale building through HR (1), arrange the scheduling of clients during the work day whenever feasible (1), create staff networking and support (1), and enforce consistent consequences for inappropriate behavior (e.g., tardiness, excess absences, lack of boundaries).
- Training solutions included ongoing training that is affordable and accessible (5); requiring trainings on EBPs, the system of care, ethics, and substance abuse (3); and working with university faculty to serve as trainers (2).
- Another respondent suggested that administrators and managers use evaluation findings to create solutions (1).

Surveys of Consumers (n=37)

What do you perceive to be the biggest challenges in receiving treatment? What are the implications of these challenges on the workforce (n=37)?

Challenges fell within four categories—workforce (28 comments), access to treatment and other resources (28), service delivery (18), and the system (7). These categories were confirmed in the focus groups of consumers. Specific responses for each are listed below.

Heading the list of workforce challenges was:

- The lack of qualified or experienced providers (8 comments).
- Other workforce issues mentioned more than once included poor pay (3 comments); the non-professionalism of workers (2); and the lack of communication between multiple providers at different agencies (2).

- Consumers also identified the following challenges: endorsement of providers (1); lack of available staff due to poor pay and benefits (1); too much reliance on the illness paradigm instead of recovery/self-determination (1); providers making decisions about services with inadequate information (1); staff unable to educate consumers about addiction (1); community support specialists not adequately trained to support their clients (1); uncaring attitudes of workers (1); burnout (1); lack of support from the provider agency to workers (1); too much emphasis on monitoring paperwork, not consumer progress towards goals (1); difficult cases closed for "non-compliance" (1); confidentiality (1); and the lack of qualified trainers (1).

Access challenges included the following:

- Identified by three consumers each were the lack of a consistent provider; the amount of time to receive treatment; and information on accessing service providers (3). Access issues pinpointed by two consumers each were access to care; lack of consumer knowledge about the role of each service provider; how to access information and referral services; availability of services; cost of services; difficulty meeting the scheduled appointment due to transportation issues; and the stigma associated with the receipt of services. Additional access challenges, identified by one consumer each, included 24/7/365 access; lack of adequate health insurance; difficulty getting appointments scheduled; providers not showing up for their appointments on time; and procedures for accessing vocational rehabilitation services.

Service Delivery Challenges:

- Consumers identified the lack of or limited treatment services (four comments); the loss of services, including perceived movement away from having parents care for their adult children (3); and fragmented services (2) as challenges related to service delivery.
- Other service delivery challenges, identified by one consumer each, included inadequate funding; need for commitment to best practices; lack of timely and thorough treatment; lack of qualified programs; lack of qualified supports; lack of SA treatment services; lack of understanding about traumatic brain injury; lack of consumer educational materials; and no central clearinghouse for information on services.

Systems challenges included the following:

- Lack of services in rural areas (3 comments) and
- Lack of understanding of the system and consumer rights (1).
- The system was characterized as constantly changing (1 comment); dysfunctional (1); or broken (1).

Implications on the workforce of these challenges were not generally addressed. However, when implications were addressed, consumers noted that these challenges meant that fewer individuals were entering these professions, leading to greater stress, burnout, and turnover. Two consumers interpreted the question from their perspective, stating that without adequate supports, consumers with these disabilities would either leave the workforce or problems would result in less or lost productivity.

On what topic areas do recent graduates need further training (n=34)?

Consumers identified two topic areas—those related to interpersonal relationships and those related to services provided.

- For topic areas related to interpersonal relationships, consumers made 22 comments related to cultural competency (1), including religious and spiritual practices in rural areas (2); communication skills, including interpersonal relationships (1), interviewing skills (1), and conflict resolution (1) as well as developing non or limited verbal skills (2), working with low income consumers (1); professionalism (1) and ethics (1), including respect (4), compassion (2), interagency collaboration (1), and HIPAA (1); advocacy (2); and stigma (1).
- For those related to services provided, consumers made 44 comments and identified person-centered planning (3), with real-world experiences (2), getting people support, education, and jobs (2), and securing benefits for consumers (1); evidence-based practices (3), including co-occurring disorders training (3), training on behavioral interventions (3), cross training on the three disabilities (3), training on mental illness (2), training on traumatic brain injury (2), training in general (2), crisis response (1), strength-based therapy (1), autism (1), and medications (1); community resources (4), including natural supports (1); recovery (5); consumer involvement (1); peer support (1); self-determination (1); and how to run a business (1).

What skill set is needed to sustain a workforce (n=35)?

- evidence-based practices (3 comments)
- professionalism, including respect for consumers (4), boundaries (2), core functions of jobs (1), professional actions and dress (1), and work ethic (1)
- people skills (2), including cultural competency (4), interpersonal skills (4), communication skills (4), personal responsibility (3), empathy (2), flexibility (2), ability to offer hope (2), proficiency in English and math (1), interviewing skills (1), active listening skills (1), reflection skills (1); team work (1), conflict management (1), creative problem solving (1), maturity (1), good judgment (1), tenacity (1), sensitivity (1), dependability (1), ability to validate consumers' efforts and knowledge (1), and follow-through skills (1)
- person-centered planning (4), including counseling skills (1); implementing and monitoring treatment plan (1); recovery (2); self-determination (2)
- systems transformation (1)
- stigma (1)
- natural supports in treatment (1)
- community building skills (1)

Consumers thought that training should be ongoing (4 comments) and include coaching (1 comment). In addition, consumers stated that supervisors/managers need to understand the roles and functions of the workforce, be fair, be open to feedback, and engage workers in problem solving. They also recommended higher salaries (1) and benefits (2), and support for providers from the system (2).

Cultural competency has been a hot topic in the workforce in recent years. How does sensitivity to ethnic, cultural, and other special issues make a difference in treatment (n=35)?

Consensus on the survey indicated that cultural competency makes a huge difference in consumers being treated with respect as an individual, with five consumers specifically stating its important role. Respect was a theme that consumers reiterated time and again in both the survey and focus groups.

- Eight consumers identified respect or sensitivity as making a difference.
- Another seven comments indicated that cultural competency increased provider understanding of consumers,
- Six suggested a person-centered approach to ensure that cultural differences were addressed, and
- Two felt that it increased client engagement and retention.
- Two consumers felt that socioeconomics, not race or gender, is what makes a difference.
- One consumer noted that cultural competency is the ideal but not always possible in practice. More training was suggested by one consumer while another that there are language barriers in some areas. Two thought that cultural competency was unimportant.

What would make the biggest difference in receiving treatment (n=35)?

- For survey respondents, access to services received the most comments (40).
  - Comments related to access included the need for consistent and reliable care (8 comments); for consumer-specific services and supports (person-centered) with meaningful outcomes (7); for caring and sensitive providers (6); and for a continuum of care (2). Consumers suggested that the number of qualified providers be increased (4 comments), that care be affordable (1), and that funding be increased for community resources (2), reimbursement (1), for money to follow the consumer (1), and for follow-up services (1). Other comments included increasing access to care through viable transportation (1); developing natural supports in the community (1); allowing family members to provide care (1); addressing trauma issues for those who use crisis services (1); educating police, fire, rescue, teachers, social workers, and human resource departments of companies (1); increasing interagency communication and collaboration (1); and educating providers to understand the system so that they can explain it to consumers and their families (1).
  - In addition consumers wanted to be treated with dignity and respect (2 comments); agencies to focus on consumers, not revenue (1); agencies to provide cross-training education and experience (1); providers to work with them in partnership (1); and providers to identify meaningful jobs for them (1). One asked that the state close down providers that do not know how to provide services, and another wanted providers to separate payee issues from treatment issues for consumers receiving community support and SSI.

Survey of Trainers (n=13)

What skill set is needed to sustain a workforce (e.g., evidence-based practices, cultural competency) (n=13)?

- Evidence-based practices (7 respondents)
- Cultural competency (5)
- Professionalism, including boundaries, ethics (3)
- Person-centeredness (2)
- DSM/diagnosis (2)
- People skills (1)
- Systems transformation (1)
- Community support (1)
- QP (1)
- Documentation (1)
- Family therapy (1)
- Group therapy (1)
- Recovery (1)
- Management and leadership skills (1)
- Stress management (1)

How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis) (n=12)?

Like providers and HR managers, the primary strategy for addressing the needs of special populations was taking a person-centered approach to care (identified by half the trainers). Other ways included the offering of special programs (3), training (2), developing cultural competency with special populations (2), and the offering of wraparound services (1).

What training is needed for personnel (direct care and professional) (n=13)?

- Evidence-based practices and basic treatment information tied, with four respondents identifying each.
- Two individuals mentioned documentation, writing person-centered plans, community support, and professionalism. Additional training included the following, mentioned by one respondent each: understanding of the human services field, state requirements, goal writing, basic writing, communication skills, cultural competency, healthcare training, first aid, CPR, family therapy, group therapy, substance abuse resources, recovery, clients' rights, consumer-specific training, management and leadership skills, stress management skills, and demonstrating that they are valued by the organization.

What barriers exist to building a competent workforce (n=13)?

The lack of experienced workers and access to training were most frequently cited as barriers by four individuals each.

- Two respondents mentioned the inordinate amount of paperwork required by the system, and two others mentioned the insufficient rate schedule.
- Other barriers included lack of education about mental illness; poor pay; hours; staff disinterest in training; lack of supervision; differing expectations between providers and frontline workers; management/leadership not expected to attend training so organizations may not operate from a mission-driven or consumer-driven perspective; lack of knowledge about the system; low expectations and little to no guidance from the Division of MH/DD/SAS; lack of a standard curriculum or required certification; staff attitudes; and stigma.

What solutions can be shared to address the challenges in building/sustaining a competent workforce (n=13)?

Trainers tended to list training as the primary solution for building/ sustaining the workforce (6 comments).

- Other solutions cited by one respondent each were the following: making changes in the system, increasing the reimbursement rates, having a clear mission, having clear expectations for workers, making statewide trainers available due to the expense of conducting onsite training, mandating core training with recertification review, providing cross training for the three disabilities, hiring experienced workers, working with the universities, using the training of trainers model, and using technology to train workers (e.g., online courses).

Survey of Educators (n=2)

Only two individuals responded to the survey; they both answered all survey items. This finding in itself is indicative of a larger problem—that educators are either not aware of the implications of the state's mental health system transformation or are too busy to respond to the survey. In either case, it is not possible to generalize the perceptions of educators throughout the state from the responses of two individuals. While it is clear that one respondent is a faculty member at a community college, it is not evident whether the other respondent is at the baccalaureate or graduate school level. Both respondents do provide insight on issues facing the public sector workforce.

In what ways has the transformation of the public service delivery system affected your institution's curriculum?

The community college faculty member stated that transformation has "shaped the curriculum's focus, including how specific coursework is delivered" and emphasized that they are interested in adequately preparing their students to succeed in the marketplace. The other respondent noted that there have been few opportunities to

learn about the system's changes and that they are behind in integrating this information into their curriculum. This latter response points to the need to educate faculty about mental health systems transformation so that they can provide the necessary information, skill building, and work experiences.

How can the public sector workforce attract your graduates?

Suggestions for treatment facilities included publicizing job openings and internships, sending recruiters to the schools, and developing job opportunities for associate-level human services professionals. Additional recommendations included informing educators about the service definitions and work practices and developing "a way for non-licensed graduates to obtain the necessary hours for licensure".

In what ways are you preparing your students for jobs in the public sector (e.g., state transformation, evidence-based practices, cultural competency, co-occurring disorders, special populations)?

The community college offers introductory coursework that addresses all three disabilities as well as "case management, counseling, crisis intervention, group work, law, ethics, diversity, human development, family dynamics, social work/social welfare issues and managerial/organizational dynamics". Another expectation is for students to research the needs of special populations. Other strategies included instruction on evidence-based practices and licensure.

How does licensure affect the academic preparation of your students?

While the community college faculty member did not think that licensure had any effect, the other respondent stated that they followed the core areas of licensure and ensured that the required supervision was available.

In what ways do you currently collaborate with local treatment agencies (e.g., practicums)?

Collaborative endeavors included practicums and internships; guest speakers in the classroom; required research, visits, or volunteerism at the agencies; and required interviews of local professionals.

What barriers exist to working with treatment agencies (e.g., lack of clinical supervision)?

Barriers included lack of clinical supervision including inconsistencies in the quality of service provision; lack of appreciation of training and skills of associate-level professionals; lack of range of job opportunities for associate-level practitioners; fragmentation of the service delivery system; and lack of time and workload demands of working professionals. Perhaps the biggest barrier related to agency-based practicums was the difficulty in compensating students for their work due to their inability to bill.

Focus Groups

Focus Groups of Consumers (n=35)

What do you perceive are the biggest challenges in receiving services and support? What are the implications of these challenges on the workforce?

Consumers identified similar challenges as mentioned in consumer online surveys. The primary difference was that focus groups tended to emphasize training issues more than did the consumer online surveys. These challenges are listed below:

- Issues related to workforce (24 comments)
- access (20)
- service delivery (9)
- personal consumer issues (7)
- funding (6)
- paperwork and new policies (4)
- unethical practices of an agency (1)

In terms of workforce issues, ten comments related to the need for additional training, with specific types of training cited: disability-specific (2 comments) or skill-based (1) or on topics such as motivational interviewing (1), child and family systems (1), assessing for SSDI (1), crisis intervention (1), applying the basic concepts of person-centered planning (1), traumatic brain injury (1), and behavioral issues (1). Other workforce issues included turnover, particularly paraprofessionals (4 comments), underpaid staff (3), the hiring of unqualified staff (2), an insufficient number of staff (2), too many administrators (1), and the inability of provisionally licensed staff to bill (1) (misconception). One consumer stated that the Division of Social Services staff needed training on disability-related issues.

Access to services was also frequently cited in the focus groups. Consumers stated that access to community resources was an issue, with families not knowing where to go (4 comments), providers not familiar with the resources (1), the lack of a list of qualified providers (1), need for guidance in selecting a provider (1), and no Internet access to identify existing resources (1). Other access issues included waiting lists (3 comments), the denial of appropriate services (3), the lack of consumer education (3), stigma (2), and lack of advocacy and support (1).

In terms of service delivery, the need for individualized care (3 comments) and the perception that the provision of services was resource- or Medicaid-driven (3) were most commonly noted. Also mentioned were the need for interagency collaboration (1), tighter monitoring of workforce by the LMEs and the State (1), and the perception that the LME was more responsive to the area board than to the consumers (1).

Consumers identified personal challenges that they faced; each challenge was cited once. They included illiteracy; the justice system's reliance on incarceration not treatment; lack of health insurance; limited child care; no public transportation; the social services timeline related to getting clean and child custody; and social services' emphasis on work, not school.

Funding was related to the agency and to themselves. In terms of the agency, the following issues were identified: the pay rate and structure (2 comments), the perception that the agency was profit-driven (2), and too much reliance on a single stream of funding (1). Consumers thought they would lose money for their services and feared paybacks (2 comments).

Consumers thought that the amount of paperwork had increased as a result of new policies. They felt that it led to insufficient service delivery (2 comments), that the process had become more important than meeting the needs of the individual consumer (1), and that changes in forms and processes had been mandated with little or no guidance (1).

One consumer mentioned unethical practices of an agency but did not substantiate his/her allegation.

On what topic areas does staff need further training?

Responses in the focus groups were similar to the responses in the surveys, in that topics fell into two categories—those related to interpersonal relationships and those related to services provided. For topic areas related to interpersonal relationships,

- respect (8 comments) topped the list, followed by two comments on each of the following: cultural competency, communication skills, and ethics (i.e., confidentiality).
- Also identified were non-verbal communication (e.g., sign language) (1), sensitivity training (1), clients' rights and dignity (1), and empowering people (1).

For topic areas related to services provided, two comments were made on each of the following:

- expectations for each service provided, clinical skills, disability-specific training, cross training on the three disabilities, MH/SA training of staff in the health care system, family dynamics, domestic violence, community resources, and developing a person-centered plan.
- Other topics included skill building for consumers (e.g., activities of daily living, socialization) (1), ways to support the individual and family members (1), MH/SA training of staff in the justice system (1), SA/MH (1), sexual abuse (1), child development (1), SA treatment for youth (1), crisis intervention (1), peer education (1), administering a drug screen (1), and how to plan the future with the consumer after a parent dies (1).

In addition to topics for training, consumers reiterated some of the challenges noted for the first question. They stated that staff members are inadequately trained (3 comments) and underpaid (3), that they need to be invested in their jobs (2) and keep their skills current (1), and that on-the-job training should be offered (1).

Cultural competency has been a hot topic in the workforce in recent years. How do sensitivity to ethnic, cultural, and other special issues make a difference in treatment?

As in the online surveys, focus group members agreed that cultural competency is critical in treatment. Four thought that culture needs to be taken into account when providing services to consumers;

- Two advocated for training on understanding differences in ethnicity and culture and being able to communicate and relate to individuals who have these issues in their lives;
- Two promoted cultural understanding; and two emphasized the importance of respect.
- Others commented on the use of the person-centered plan in obtaining consumer and family input (1); the need to change the values of the funding agency so that cultural issues are taken into account in providing services (1); and the belief that culturally competent treatment involves the support structure that each consumer needs (1).

What would make the biggest difference in receiving treatment?

Focus group consumers also identified similar issues related to access to services as making the biggest difference in receiving treatment (19 comments):

- More long-term treatment programs (3 comments)
- Insufficient number of treatment beds (2)
- Need for reimbursement of talk therapy (2)
- Consideration of demographics in providing services due to different issues/concerns at different stages of life (2)
- Detox needed for crack and cocaine (1)
- Need to reduce wait time for treatment (1)
- Need to market services that different facilities provide (1)
- Having necessary services, supports, and facilities (1)
- Establishing a neurobehavioral center (1)
- Making the system more user friendly (1)
- Decreasing paperwork and authorization process (1)
- Increasing number of healthcare providers who accept Medicaid (1)
- Providing education about MH reform for consumers and community at large as well as county commissioners, DSS, and Child Protective Services (1)
- Informing consumers about community resources (i.e., AA, NA) prior to discharge (1)

Respect was reiterated and was mentioned five times by focus group members. Also noted were the need to provide more education and skills-based training for staff (2 comments); more cross training for disabilities, with emphasis on individual's needs (1); a shift in focus from disability to humanity (1); ensuring that the person-centered plan remains responsive to the consumer's needs (1); the separation of DD from MH and SA since it is not a disease (1); and the provision of respite services for family members (1).

What do the people who provide you with support and services need to know to be able to do a good job?

Responses to this question were in two categories: training and personal behaviors of the provider.

In terms of training,

- Consumers felt that they needed familiarity with available community resources (e.g., health, education, social services, legal services) in order to make informed decisions and obtain what they need (5 comments) was essential.
- Other topics of training were education on child development (3), disability-specific training (2), more training of providers and monitoring of services provided (2), SA education (2), MH education (1), communication skills training (1), training on business skills (1), and training on client's rights (1). Consumers also thought that providers need to understand the system so they can work around it (1) and to anticipate needs before they reach the point of crisis (1). They also suggested certification for those who provide case management and community support services

In terms of personal behaviors of providers,

- Consumers identified respect (2 comments) and thought that the focus should be on the consumer not the agency (2).
- They also believed that the provider should have the ability to instill hope (1), should know the consumer's/family's dreams (1), and know the consumer's history (1).
- In addition, consumers said that there should be more collaboration between agencies and providers (1) and that agencies should pay parents to take care of their children with disabilities (1).

Focus Groups of Providers and Human Resource (HR) Managers (n=37)

In what ways should paraprofessionals be educated about job responsibilities and careers in the public sector?

Education was discussed at several levels—pre-service, on the job, and for other stakeholders. At the pre-service level, job fairs or career exploration in schools (e.g., elementary, middle, and high schools, community colleges, and colleges) was mentioned by six providers/HR managers.

- At the community college and college levels, six providers/HR managers felt that practical experience (e.g., internships, rotations, work/study) prior to hiring was helpful in providing a realistic view of what occurs in treatment settings.
- Also useful are shadowing (1) and talking to those already in the field (1).
- Providers and HR managers advocated for a realistic preview of what a job in the field entails, with clear job descriptions and expectations delineated (10 comments) and
- A preview of the types of training paraprofessionals will receive on the job (1).
- Three (3) thought that a career path should be developed for paraprofessionals.
- Six (6) mentioned that applicants should be screened for fit and temperament/compassion/ sensitivity.
- One (1) suggested that goals needed to be matched with what is required for education and experience. Another stated that agencies should document the orientation and training that their employees receive.

In terms of training, the following were identified:

- Disability-specific training (5 comments)
- On the job training (4)
- Link between client's goal and activities (2)
- Overview of disability-specific interventions (2)
- Therapeutic boundaries (2)
- Being a member of a team (1)
- Interpersonal skills (1)
- Conflict resolution and management (1)
- Culture of families (1)
- Overview of concepts underlying the field (e.g., recovery, person-centeredness) (1)
- Work ethic (1)

Also mentioned was the need for adequate supervision (4 comments) and for educating professionals about services provided by direct care workers (1). One thought that family members should be educated about services that direct care workers provide. A provider or HR manager said that the state should mandate a required course for all paraprofessionals while another suggested that a certification courses be developed and offered to them. Additional observations included fewer opportunities for internships due to a lack of supervisors, working with community colleges, and reducing paperwork and regulations. One provider or HR manager proposed recruiting military personnel into the field.

In what ways do you currently collaborate with institutions of higher education? For example, offering practicum experiences and hiring recent graduates?

- Providers and HR managers most frequently spoke of sponsoring internships or field placements for community college or college or graduate students (13 comments) even though it is a challenge using students in unpaid practica (1).
- One provider or HR manager said that is difficult for students to obtain placements, particularly at private agencies.
- In addition, the inadequate number of supervisors on site is problematic (3 comments).
- One stated that the services of provisionally licensed staff are not reimbursable, including supervision (misconception).
- A provider or HR manager suggested that a listing of programs at colleges be compiled so that providers can target colleges for interns. An agency noted that they had collaborated with the local community college to develop their human services curriculum while another was considering doing something similar.
- Three stated that they recruited GED, community college, and/or college students for staff positions through job fairs, job boards, and listservs. Recruitment methods included sending a staff member to be a guest speaker in a college classroom (2) and using www.careerbuilder.com for recruitment (1).
- One agency said that they frequently hired interns after they graduate.
- Two suggestions were made:
    - Three focus group participants proposed that stipends, financial assistance, and incentives be available for employees to pursue educational advancement (i.e., degrees, certification, or licensure).
    - Training amenable to staff schedules (e.g., online, night, weekend) was also suggested.

As HR managers, what are the greatest strengths of recent hires? Limitations? How can institutes of higher education address these limitations?

Strengths included the following:

- Technologically savvy (3 comments),
- Altruistic (2), eager to work (2), enthusiastic (2), excited (2), flexible (2),
- Ambitious (1), compassionate (1), eager to learn (1), motivated (1), new ideas and thinking outside the box (1), teachable (1), and willing to continue education on the job.

Limitations related to the recent hires included the following:

- Lack of exposure to the field so basic training is needed (5 comments), lack of education (5),
- Not invested (4),
- underpaid (3), need for more oversight (3), lack of understanding of the terminology,
- Specific definitions of disabilities, and vocabulary (2), lack of professional boundaries (2), poor work ethics (2), inability to document (2),

- Inability to link consumer goal with activities (1), lack of basic skills (e.g., reading, writing) (1), lack of knowledge of the business end of the field (1), the younger generation is less patient and not as eager to pay their dues (1), lack of respect for consumers (1), reduced interpersonal skills (1), lack of empathy of staff (1), and non-attendance at skill-building workshops (1).
- Other limitations included colleges not keeping up with reform (1), requirements of the QP are more than providers are willing to meet (1), requirements in MH reform that BA and master's level folks don't have the ability to attain (misconception) (1), need to supervise those who are doing the supervision (1), inability for paraprofessionals to get paid when consumers do not show up (1), young people are not entering the field (1), and people are leaving the field (1).

Providers/HR managers offered the following as possible solutions for recent hires:

- More practice with critical thinking (3),
- More training for paraprofessionals (2),
- More experience in the community (2), matching of students with good mentors (2), training on documentation (2), flexible schedules to advance education (2),
- More opportunities to test themselves (1), have new graduates role play the consumers (1), training on safety situations paraprofessionals might encounter (1), and training on accountability since they are stewards of public dollars (1).

Possible solutions were also posed for other parts of the system:

- Have higher education provide the basic education for workers (1), have higher education provide disability-specific training (2), infuse ethics into coursework (1), enhance the bridge between academia and service (1), have community colleges inform agencies of new developments (1), introduce career opportunities in middle school (1), and develop business KSAs (1). Suggestions for the State include the development and maintenance of a database for those who have attended training (1), ensuring that audits are a transparent process (1), and raising the standard for expectations, pay, and accountability (1).

What is the biggest barrier in hiring recent graduates of master's level programs (e.g., supervision, licensure)?

Providers and HR managers identified barriers that related to the MH system and its implications at the local level. For those barriers related to the overall system, the following were identified:

- Service gaps in rural areas (5),
- Confusion related to what clinical services can be billed by provisionally licensed staff (3 comments) (misconception that provisionally licensed providers cannot bill),
- Fear of IPRS funds running out (2),
- Unstable system (1), service definitions are too loose (1), disconnect between service definitions, licensure, and certification (1), rate structure does not provide any incentive/support for hiring someone who is more qualified (1), and no formalized process in DD world for getting licensure (1).

Barriers at the local level related primarily to licensure and supervision. Overall, there is a need for more licensed staff to provide supervision.

- Lack of supervision (3 comments),
- Low salaries (2),
- Need for more licensed staff (1), turnover (1), loss of staff to DSS who continued to receive supervision from the agency since there were no qualified supervisors in DSS (1), and the need for staff with experience (1). Also mentioned was the inability of families to find workers (1) and the recognition that services for some clients are labor intensive (1).
- Providers/HR managers suggested that educational programs include an experience component and a program of loan forgiveness be established for those entering the field.

How do professional licensure requirements affect your decisions in hiring recent college graduates?

- An inadequate number of licensed staff (4 comments) was reiterated as a problem facing the workforce.
- Related to this problem is the need for providers to obtain experience in order to get licensed (2), non-licensed staff cannot bill (2), the outsourcing of licensed staff due to their high salaries (1),
- The need for experienced staff (1), the possibility that providers may have to pay someone to provide supervision in order to obtain their license (1), turnover (1), the desire to use post-graduate experience toward licensure (1), and the low number of self-pay clients which makes it difficult for new hires to gain necessary experience (1).
- A provider/HR manager also mentioned that master's and licensed providers are not interested in intensive in-home care due to scheduling issues.

How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis)?

- What was clear was the pervasive lack of expertise in all areas (5 comments).
- To remedy this problem, agencies are working with other agencies, both referral and cross training (3),
- Recruiting staff with expertise in these areas (2), providing disease-specific training (2), outsourcing services for special populations (2), taking a person-centered approach (2),
- Matching clients with providers (1), trying to make connections between populations and support groups but turnover and paperwork backlog mitigate these efforts (1), and educating providers and HR managers about diversity issues (1).
- Providers and HR managers also observed that care for special populations has led to fragmentation and siloing (2),
- That it is difficult to provide specialized services for special populations due to stigma (2),

- That that marginalized populations require advocacy and community education which are labor intensive (1), that diagnoses sometimes make it difficult to bill (1), that agencies fear losing patients when they collaborate with other agencies (1), that larger agencies have a more diverse workforce (1), that there is an inadequate number of QPs (1), and that large caseloads may mean a decrease in the quality of services (1). In addition, they suggested that EBPs be taught in colleges and graduate programs (1), that a diversity curriculum was needed (1), that bilingual speakers should be hired (1), that consumers be educated (1), that wheelchair accessibility was essential (1), that funding was needed (1), and that audit requirements be clearly delineated (1).

What recruitment strategies/activities could be used to build the workforce?

Providers and HR managers suggested strategies related to recruitment, screening and retention as ways to build or maintain the workforce.

For recruitment, the following activities were suggested:

- Working with middle and high schools, colleges, and graduate schools (3 comments),
- Utilizing www.careerbuilder.com (2),
- Using creative marketing to attract providers (1), marketing outside the state to attract licensed professionals (1), developing fliers (1) and handbooks for managers (1), displaying exhibits at conferences (1), conducting open houses, paying a finder's fee (1), using contingency programs (1), instituting an employee referral program with a financial incentive (1), having good benefits (1), offering a loan forgiveness program (1), and offering a hiring bonus and flexible schedules (1).

For screening, providers and HR managers suggested screening to reduce turnover (2 comments), a pre-employment drug test (1), the development and use of interviewing guides (1), and instituting standardized hiring practices (1)

For retention, the following strategies were suggested:

- The offering of educational and other incentives (4 comments),
- Making a shift in values at the agency (3),
- Ensuring that employees feel valued (2), discouraging practices that condone stealing of employees/clients (2), establishing a competency-based certification process (2), allowing job sharing among part-time staff (2),
- Increasing communication between upper management and those providing direct care (1), developing a 20-hour curriculum for community support services and uploading it to a website (1), working with community colleges to offer credit for specific training (1), counting internships as part of post graduate credit (1), developing a career path for employees (1), establishing a registry of providers with certification (1).

Two comments were made that agencies feared that once a provider receives training and educational assistance toward licensure, he/she will leave. Another said that passion is more important than education.

What solutions can be shared to address the challenges in building/sustaining a competent workforce?

Focus groups confirmed the results of the online surveys and identified solutions in the areas of administration at the state, local, and staff levels; and training.

Administrative issues at the state level include the following:

- Division perceived as arbitrary in its rules and requirements (3 comments);
- Money viewed as the bottom line for private providers, with the perception that they are making a profit (3);
- As paperwork increases, services to people suffer (3);
- System needs to stop making additional demands (2);
- Need for consistent paperwork across the LMEs (1); perception that private providers require staff to make decisions based on finances, not what is right for the individual (1); more flexibility in funding (1); funding needed for building infrastructure (1); perception of funding disparities, with SA getting all the money (misconception) (1); redistribute money from regional centers to local communities (1); and regionalization of service provision viewed as negative (1).

At the agency level, administrative issues included the following:

- More leadership at the agency level (2);
- More oversight and supervision (1); evaluation of quality of learning of the staff to create support network for service users (1); the use of the screening process to determine applicants who would be a good fit (1); teaching managerial and supervisory staff about customer service (1); emphasis on clinical integrity, where interventions are selected that best suit the individual (1); communication about the agency (1); and becoming acquainted with staff as individuals (1).

At the staff level, providers and HR managers identified the following issues:

- Establishing employee recognition and rewards programs (2);
- Offering EAP programs (2);
- Providing good benefits (1); increasing salaries (1); offering child care programs (1); offering transportation options (1); and publicizing career opportunities.

Training solutions focused on improving the quality of the workforce with the recognition that it takes time to build the workforce. Suggested solutions included the following: provide training and supervision of frontline workers (2); have higher education provide the training (1); provide college credit for training that staff receives (1); offer cross training (1); consistency needed across different trainings on the same topic (1); offer opportunities to learn online (1); teach stress management skills (1); establish a certification process for staff across the state, with curriculum and KSAs (1); and provide good career counseling and educational advising for young people entering the

field (1). Also mentioned was the need to establish a professional association so that the field can speak in a unified voice.

Summary

A review of the issues indicates that the stakeholders agree that providers needed training on evidence-based practices, cultural competency, disability-specific behavioral interventions, clinical documentation, and writing person-centered treatment plans; that recent hires needed more real-world experience; that professionalism and providers' respect for consumers and frontline workers was lacking; and that increasing paperwork, regulations, and system changes were taking their toll. Staff turnover, an insufficient number of providers and supervisors, underpaid and undervalued staff, and unqualified staff were also of concern. Consumers identified access to services as essential, and discussion focused on inadequacies within the system. Providers found that access to training was problematic (e.g., cost, timing, location) and that licensing requirements were worrisome due to their implications on supervision and billing. What is particularly distressing is a continued lack of understanding about Mental Health Systems Transformation. Also missing was a widespread understanding of the importance of implementing evidence-based interventions (less than one-third of respondents identified it as critical).

A number of solutions were identified. Marketing was suggested—to inform consumers and providers about Mental Health Systems Transformation, including information about billing and reimbursement and a listing of community resources in each service area. Also important was the need to provide job descriptions with explicit expectations so that potential employees were realistic about staff requirements. To increase applicant fit with the agency and to decrease turnover, screening of staff was suggested as a possible remedy. Training of staff was identified as critical, with opportunities for advancement needed. Suggestions addressed pre-service education, continuing education, educational assistance, training on specific topics, mentoring, and high-quality supervision.

Appendix A
Online Survey Questions

Educators:

1. In what ways has the transformation of the public service delivery system affected your institution's curriculum?
2. How can the public sector workforce attract your graduates?
3. In what ways are you preparing your students for jobs in the public sector (e.g., state transformation, evidence-based practices, cultural competency, co-occurring disorders, special populations)?
4. How does licensure affect the academic preparation of your students?
5. In what ways do you currently collaborate with local treatment agencies (e.g., practicums)?
6. What barriers exist in working with local treatment agencies (e.g., lack of clinical supervision)?

Providers/HR Managers:

1. On what topic areas do recent graduates need further training (e.g., evidence-based practices)?
2. In what ways should preprofessionals be educated about job responsibilities and careers in the public sector?
3. In what ways do you currently collaborate with institutions of higher education?
4. What is the biggest barrier in offering practicum experiences to preprofessional students?
5. As HR managers, what are the greatest strengths of recent hires? Limitations? How can institutions of higher education address these limitations?
6. What is the biggest barrier in hiring recent graduates of master's level programs (e.g., supervision, licensure)?
7. How does licensure affect your decisions in hiring recent graduates?
8. What skill set is needed to sustain a workforce (e.g., evidence-based practices, cultural competency)?
9. How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis)
10. What training/support is needed for personnel (direct care and professional)?
11. What recruitment strategies/activities could be used to build the workforce?
12. What incentives or retention strategies should be instituted?
13. What solutions can be shared to address the challenges in building/sustaining a competent workforce?

Trainers:

1. What skill set is needed to sustain a workforce (e.g., evidence-based practices, cultural competency)?
2. How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis)
3. What training/support is needed for personnel (direct care and professional)?
4. What barriers exist in building a competent workforce?
5. What solutions can be shared to address the challenges in building/sustaining a competent workforce?

Consumers and Families:

1. What do you perceive are the biggest challenges in receiving treatment? What are the implications of these challenges on the workforce?
2. On what topic areas do recent graduates need further training?
3. What skill set is needed to sustain a workforce?
4. Cultural competency has been a hot topic in the workforce in recent years. How does sensitivity to ethnic, cultural, and other special issues make a difference in treatment?
5. What would make the biggest difference in receiving treatment?

Appendix B
Focus Group Questions

Providers/HR Managers:

1. On what topic areas do recent graduates need further training (e.g., evidence-based practices)?
2. In what ways should paraprofessionals be educated about job responsibilities and careers in the public sector?
3. In what ways do you currently collaborate with institutions of higher education?
4. What is the biggest barrier in offering practicum experiences to paraprofessional students?
5. As HR managers, what are the greatest strengths of recent hires? Limitations? How can institutions of higher education address these limitations?
6. What is the biggest barrier in hiring recent graduates of master's level programs (e.g., supervision, licensure)?
7. How does licensure affect your decisions in hiring recent graduates?
8. What skill set is needed to sustain a workforce (e.g., evidence-based practices, cultural competency)?
9. How do you address the needs of special populations (e.g., women, adolescents, GLBT, seniors, veterans, criminal justice, co-occurring disorders, HIV/AIDS, hepatitis)
10. What training/support is needed for personnel (direct care and professional)?
11. What recruitment strategies/activities could be used to build the workforce?
12. What incentives or retention strategies should be instituted?
13. What solutions can be shared to address the challenges in building/sustaining a competent workforce?

Consumers and Families:

1. What do you perceive are the biggest challenges in receiving treatment? What are the implications of these challenges on the workforce?
2. On what topic areas do recent graduates need further training?
3. What skill set is needed to sustain a workforce?
4. Cultural competency has been a hot topic in the workforce in recent years. How does sensitivity to ethnic, cultural, and other special issues make a difference in treatment?
5. What would make the biggest difference in receiving treatment?